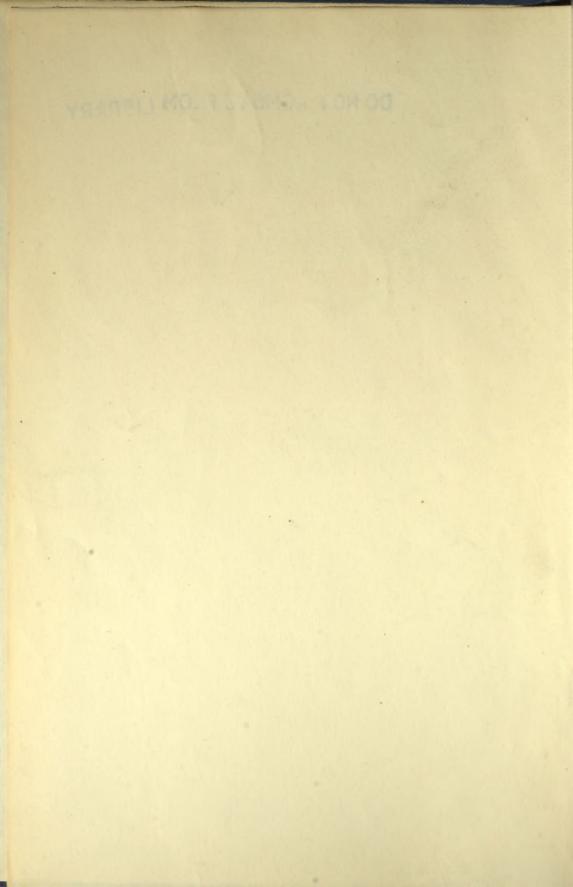


DO NOT REMOVE FROM LIBRARY



VOLUME 43 NUMBER 1 MONTREAL JANUARY 1947

THE CANADIAN NURSE



The Rh Factor by

Dr. R. L. Denton

The Nurse and Cancer Control

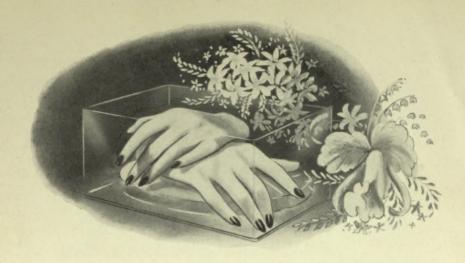
by Alice K. Smith



Alpha and Omega



OWNED AND PUBLISHED BY



When you say "USEFUL" hands, LISP!

KEEPING useful hands youthful is a problem, and nowhere is this truer than in the nursing profession. Passive, useless hands require a minimum of care. Active hands need active measures.

Counteract the innumerable washings necessary in any hospital and keep your hands soft, white and attractive by using 'Wellcome' BRAND Toilet Lanoline daily. Massaged gently into the hands every night and, used more sparingly, in the morning after washing, this soft, soothing cream will supplement the natural oils of the skin and give "on duty" hands that "off duty" look.

Tubes of two sizes at all reliable pharmacies.

"WELLCOME"

Toilet Lanoline



BURROUGHS WELLCOME & CO.

(The Wellcome Foundation Ltd.)
MONTREAL

For a generous free sample simply mail this card to P.O. Box 159, Montreal.

Please	send	me	a free	sample	of	Wellcome	BRAND
Toilet .	Lanol	ine.					

Name.....

Address

CANADIAN NURSE

Volume 43

JANUARY = DECEMBER

1947

INDEX

OWNED AND PUBLISHED BY

Authorized as second-class mail, Post Office Department, Ottawa.

**Editor and Business Manager:*

MARGARET E. KERR, M.A., R.N., Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.O.

EDITORIAL BOARD

Chairman - Mary S. Mathewson Esther Beith Fanny Munroe

EDITORIAL CONSULTANTS

Alberta - - - - - - - Margaret Cogswell British Columbia - - - - - - Elizabeth Braund Manitoba - - - - - - - - - Anna Spence New Brunswick - - - - - - Margaret Pringle Nova Scotia - - - - - - - - - - Marion Shore Ontario - - - - - - - - - - - - Buth I. Ross Quebec - Suzanne Giroux and Winnifred MacLean Saskatchewan - - - - - - - Elizabeth Smith

EXECUTIVE OFFICERS CANADIAN NURSES' ASSOCIATION

General Secretary - GERTRUDE M. HALL Assistant Secretary - WINNIFRED COOKE

Subscription Rates: \$3.00 per year — \$5.00 for 2 years; Foreign & U.S.A., \$3.50; Student Nurses, \$2.00 per year — \$5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content. News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published in March, June, Sept. & Dec. issues.

Address all communications to Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.O.

Index to Volume 43

January — December 1947

The material in this Index is arranged under subjects, authors and titles. Titles are given in full with the author's name.

The following abbreviations appear in this Index:

A.I.C. — Association des Infirmières du Canada

C.N.A. - Canadian Nurses' Association

(ed.) - editorial

I.C.N. - International Council of Nurses

N.L.N.E. - National League of Nursing Education

N.O.P.H.N. - National Organization for Public Health Nursing

(por.) — portrait (rev.) — book review

The page numbers included in each issue of Volume 43 are shown below:

January	Julypp. 497—576
Februarypp. 81—160	Augustpp. 577—656
Marchpp. 161—248	September
Aprilpp. 249—328	Octoberpp. 745—824
Maypp. 329—408	November
Junepp. 409—496	Decemberpp. 905—992

Adams, Carol M., 332
Operating-room experience for the student nurse, 370
Agnew, Harvey, 660
Solution must be found, 696
Adde ou auxiliaire en Manitoba (Waugh), 373
Adde tuberculosis for nurses (Houghton, Sellors) (rev.), 68
Adde ambulance service, 365
Adde ambulance service, 365
Notes on nursing by Florence Nightingale (rev.), 640
Study of isolation technique, 946
Alberta:
Annual meeting in (Rogers), 626
Appointments, transfers, resignations, 70, 149, 398, 724, 813

Coverage given nurses by the Workmen's

Interim reports of provincial activities,

News notes, 226, 319, 400, 479, 563, 645,

Rapport du congrès d'Atlantic City (1947).

Official directory, 240, 488, 736, 984

Compensation Act, 547

47, 460

ALLARD, Sœur

ALLER, Elsie, 801
ALLER, Raymond B.

Medical education and the changing order (rev.), 148
ALUMINUM utensil dangers false, 698
AMERICAN hospital (Corwin) (rev.), 221
AMERICAN Nurses' Association:
Labor relations, 303
Report of biennial convention, 46
An equation (ed.), 343
ANATOMICAL charts for the training of nurses (rev.), 390
ANDERSON, B. E., Lesnik
Legal aspects of nursing (rev.), 966
ANDERSON, O. W., Sinai, Dollar
Health insurance in the United States (rev.), 721
ANNESLEY, Katie
Psychology of growth (Beverly) (rev.), 640
ANNUAL meetings:
Alberta (Rogers), 626

ALLBEE, Geraldine

Bacterial pericarditis, 881

ANNUAL meetings:
Alberta (Rogers), 626
British Columbia (Wright), 628
Manitoba (Fair), 631
New Brunswick (Law), 52
Nova Scotia (Watson), 797

Ontario (Fitzgerald), 54, 631 Quebec (Upton), 798 Saskatchewan (Ell's), 632 Victorian Order of Nurses for Canada, 633 ANNUITIES and pensions: Leisure years — pleasure years (Gray), ANNUNCIATA, Sister Nurses textbook of anatomy and physiology (Spencer) (rev.), 221 Answer to Evelyn, 219 ARCHIBALD, Muriel Anatomical charts for the training of nurses (rev.), 390 ARMSTRONG, Gertrude, 332 Delivery room technique, 349 ARTHRITIS, 952 ARTIFICIAL hand, 395 AUXILIATRICE, Sœur Marie Lit orthopédique, 43 AVERILL, L. A., Kempf Psychology applied to nursing (rev.), 808 BACTERIAL pericarditis (Allbee), 881 BADEAUX, Georgine, 500 Emploi du B.C.G., 537 BAFFIN Land - the place of the buck deer (Rundle), 66 BAIRD, K. A. Dermatology for nurses (rev.), 640 BAIRD, Lila M. (por.), 213
BALLANTINE, Dorothy Forsythe, 801 BARR, Katherine, 4, 961 Use of the volunteer worker in a public health nursing service, 35 Bartlett, Minnie, 299 Portrait, 298 BARTSCH, Hilda, 4 Superintendent does the buying, 25 BARTSCH, Louise (Honey), 332 Cost analysis of a school of nursing, 367 BATES, Marion (Stillwell), 801 Portrait, 801 BEATRICE, Sister Mary, 748 Transfers, discharges, and methods of resigning, 783 BEATTIE, Barbara A Practice of mental nursing (Houliston) (rev.), 967 Bedside nursing - an essential service (Charter), 281 Bedside nursing - an essential service (Rowles), 190 Before they see the light of day (Nicolle), BEHRENDT, Dorothy May, 869 Bell, Barbara, 252 Serving hospital meals attractively, 279 Bell, Louise Price, 252 It's not the patient . . . it's the visitors, 277 BENIDICKSON, W. M. (por.), 512 BERTRAND, Theodora R. (por.), 58 BEVERLY, Bert I. Psychology of growth (rev.), 640 BINGEMAN, Alice Ethel (por.), 869 BLACK, Isobel, 660, 869 Group study at the veterans' village, 703 Portrait, 869

BLACKALL, Phyllis (Reeve), 908 Practical side of evaluation, 939 BLAKE, Florence G., Jeans, Rand Essentials of pediatrics (rev.), 474 BLOOD conditions Practical importance of the Rh factor (Denton), 23 Body mechanics in nursing arts (Fash) (rev.), 147 Book reviews: Listed alphabetically under authors' names and subject headings indicated by: (rev.) Botsford, Marion E., 580, 961 Job analysis, 611 Brand, Ida (por.), 299 BRITISH Columbia: Annual meeting in (Wright), 628 Appointments, transfers, resignations, 149, Centralized school of nursing, 461 Coverage given nurses by the Workmen's Compensation Act, 547 Interim reports of provincial activities, 47, 460 Joint planning committee on nursing, 460 News notes, 153, 226, 319, 401, 564, 646, 730, 818, 897, 973 Official directory, 240, 488, 736, 984 British Empire nurses war memorial fund, 709 British nurses relief fund, 624, 871 Committee, 206 Resolution, 137 Browne, Jean E., 543 Burns and scalds, 440 BURRY. Edgeworth Infant and child in health and disease (Zahorsky, Noyes) (rev.), 965 CALDERWOOD, C., Funsten Orthopedic nursing (rev.), 392 CAMERON, D. Ewen, 84 Guilt and anxiety as social controls, 107 CAMPBELL, A. D., Shannon Gynecology for nurses (rev.), 314 CAMPBELL, Priscilla, 56, 377, 828 Portrait, 56 Start talking, 844 CANADA'S food rules, 360 CANADIAN Citizenship Act analyzed, 539 CANADIAN Nurses' Association: Affiliation fees, 208 Biennial meeting (1948), 791, 871 Executive committee meeting, 137, 303, 544, 871 General secretary's report, 544 Incorporation, 208, 512 New members of executive committee, 208 Nurses' interests, 871 Questionnaires, 382, 871, 953 Representatives from the nursing sisterhoods, 208 Third vice-president, 208 Treasurer's report, 545 Voting body at general or special meetings, 208 CANADIAN Nurses' Association resolutions:
Articles in The Canadian Nurse, 548

British nurses relief fund, 137, 207

Discrimination in the employment of married women, 205 Gift of Canadian Red Cross Society, 138 CLAY, R. C. C. New system of first aid (rev.), 722 CLERMONT, Sister Delia (por.), 57 Income tax for married women, 137 CLITICAL facilities, expansion of (Penhale), No racial discrimination, 953 948 Opposed to lowering of educational COATES, Hilda requirements, 137 Library housecleaning, 809 President's sub-committee, 137 COCHRAN, Marian Procedure for handling securities, 548 Home-made incubator, 220 CANADIAN Nurses' Association is incorporated (Flanagan), 512 Color atlas of hematology (Kracke) (rev.), 890 CANADIAN Red Cross Society: G.ft, 22, 138 Staff changes, 399, 724, 970 COMMUNICABLE disease techniques (Shepherd), 929 COMMUNICABLE diseases: CANADIAN Scientific Film Association, 397 Communicable disease techniques (Shep-CANCER: herd), 929 Is cancer increasing (MacPherson), 117 Flu virus exists in several forms, 224 Late cancer case (Young), 195 Immunity to mumps, 292 Leukemia, 928 Isolation technique, a study of (Aitkenhead), 946 Nurse and cancer control (Smith), 28 Role of pathology in cancer control Poliomyelitis (McIntosh), 779 (Kurtz), 437 Swelling of the arm, 867 Tetanus (Thomson), 144 Why immunize, 702 CANTIN, Marie E. Manuel de l'infirmière visiteuse (rev.), CONNOLLY, Mary P. (por.), 56 CONNOR, Anne Bernice, 580 Student nurse and chronic illness, 599 CANTOR, Max M., 748 Conseil International des Infirmières, 49 Chemical research and medical progress, Consultation vans for infants, 372 761 Cooke, R. Gordon CAPELLE, Pauline, 748 Summary of medicine for nurses (rev.) Why I choose nursing, 777 CARDEX system for nurses' orders (Richard-COOPER, Irene son, MacLeod), 379 Gynecology for nurses (Campbell, Shan-CARE of the chronically ill (Rowe, Lenon) (rev.), 314 Warne, Wilson), 596 COPELAND, Elizabeth E. (por.), 213 CARE of the unmarried mother and her child CORAMINE — a life saver (MacIntosh), 774 (Philpott, Goodwin), 357 CARPENTER, Anne CORWIN, E. H. L. American hospital (rev.), 221 Solutions and dosage (Jamison) (rev.), Cost analysis of a school of nursing (Honey, Bartsch), 367
COUGHLIN, E. 806 Carson, Agnes D. (por.), 377 CAWKER, Charles A., 500 Exploratory laparotomy, 311 Courlander, Kathleen Nursing care of urologic patients, 514 CHARBONNEAU, Marie Louise Gabrielle, 130 Women volunteer to aid hospitals, 717 Portrait, 130 Cox, Agnes, 803 CHARTER, Christine E., 42, 252 CRANNA, Elva Bedside nursing — an essential service, Nurse-patient relationships in psychiatry (Render) (rev.), 967 CHEMICAL research and medical progress CRAWFORD, Catherine H. (Cantor), 761 Ward hypodermic tray, 142 CHINESE medicine, early, 982 CRAWFORD, H. Ruth, 252, 412 Сніттіск, Rae, 4 Meal planning and preparation, 434 Our threatened values (ed.), 21 Nutrition education and the public health CHRISTMAS day in a Jap prison, 920 CHRONIC illness nurse, 270 CREATING rapport (ed.), 837 Care of the chronically ill (Rowe, Le-CREELMAN, Lyle M., 500 With UNRRA in Germany, 532, 605, 710 CRYDERMAN, Ethel M., 952 Warne, Wilson), 596 Health problems of an aging population (Hall), 591 DATA on student nurse enrolment in schools Occupational therapy for the chronically $\sqrt{}$ of nursing in Canada, 384 DAVIES, G. E., 660 ill (Driver), 602 Student nurse and chronic illness (Connor), 599
CHRONIC illness (Gelbach), 594 DÉCARY, Sister M., 828 Hospital penicillin treatment centre, 847 Delivery room technique (Armstrong), 340 CLAIRE, Sister M. Diahetic care Stern, Rosenthal) (rev.), 69 DEMONSTRATION school, 22, 215, 712, 793 DENMAN, Elsie Eye, car, nose and throat manual for CLARE, Sister Evelyn

Gastric ulcer, 557

nurses (Parkinson) (rev.), 314

Nursing in eye, car, nose and throat (Hol-Essentials of pediatrics (Jeans, Rand, lender, Snitman) (rev.), 222 DENSFORD, Katharine J., 660 DENTON, R. L., 4 Blake) (rev.), 474 ETUDE sur une affiliation dans sanatorium de tuberculeux, 619 Practical importance of the Rh factor, 23 ETUDE sur la réhabilitation des anciens tuberculeux (Germain), 787 DERMATOLOGY for nurses (Baird) (rev.), (140) EVALUATION, the practical side of (Black-DIABETIC care in pictures (Rosenthal, Stern, all), 939 EXCHANGE of nurses committee, 623 Rosenthal) (rev.), 69 Dollar, M. L., Anderson, Sinai EXPANSION of clinical facilities (Penhale), Health insurance in the United States (rev.), 721 Douglas, May G. Exploratory laparotomy (Coughlin), 311 Eye, car, nose and throat manual for nurses Organizing a well baby clinic, 36 DRIVER, Muriel F., 580 (Parkinson) (rev.), 314 Eye care (Thompson), 266 Occupational therapy for the chronically FAIR, Laura B. ill, 602 Annual meeting in Manitoba, 631 DROVER, Olga, 869 FAIRLEY, Grace M., 660 DRUGS: FASH, Bernice Bacterial resistance, 181 Body mechanics in nursing arts (rev.), Coramine — a life saver (MacIntosh), 147 FIDLER, Nettie D., 454, 545, 748 Crude liver extract, 719 Dangers of boric acid, 642 Ontario seeks new nursing bill (ed.), 759 First Aid: Furacin, 62 Resuscitation of the drowned (Pampana), Industrial dusts can be poisonous, 803 560 FISHER, Walter J., 828 Shock therapy, 839 Rutin, 396 Some medicinal plants (Hamilton), 769 Streptomycin, 278 FITZGERALD, Matilda E Vasoconstrictor drugs, 716 Annual meeting in Ontario, 54, 631 Textbook for psychiatric attendants (rev.), 721

FLANAGAN, Eileen C.
Canadian Nurses' Association is incorporated 512 Dubbin, Mabel, 802 DULMAGE, Margaret, 300 Portrait, 300, 852 Easy crafts (Jaeger) (rev.), 890 EDITORIALS An equation, 343 ated, 512 Creating rapport, 837 Food poisoning (Mitman), 878 I am a Canadian, 425 Foot care and exercise, 118 I.C.N. congress (1947) (Hall), 673 Foreign countries Manitoba's watchtower (Seeman), Australia, 292, 875 Bermuda, 652 China, 217 Nova Scotia reviews (Grady), 589 Ontario seeks new nursing bill (Fidler), Germany, 285, 532, 605, 710 Our threatened values (Chittick), 21 Princess weds, 838 Progress in Saskatchewan (Harrison), Great Britain, 48, 134, 303, 381, 460, 935 Greece, 446, 873 South Africa, 224, 693, 712 Sweden, 682 Providing the keys, 99 Forest, Sœur Jeanne Vacation thoughts, 511 "Where we gone," 919 Soin des malades, principes et techniques (Sœurs Grises) (rev.), 967 EDUCATIONAL policy: FREEMAN, Vera M., Outpost work at Atlin, B.C., 315 Committee functions, 215 Demonstration school administration com-FRITH, Catherine (por.), 455 FRITH, Monica mittee, 215 Demonstration school of nursing, 308, 712 Health insurance in the United States Educational policy, committee on, 545 (Sinai, Anderson, Dollar) (rev.), 721 Effective living (Turner, McHose) (rev.), 964 Frost-bite (Riddell), Funsten, R. V., Calderwood Orthopedic nursing (rev.), 392 ELECTROENCEPHALOGRAPHY (Jasper, Jasper), GARDNER, Mary S. Ellis, K. W. Katharine Kent (rev.), 476 Annual meeting in Saskatchewan, 632 GASTRIC ulcer (Clare), 557 EMPLOI du B. C. G. (Badeaux), 537 GAUM, A. Historical sketch of medicine, 58 Data on student nurse, 384 Gelbach, Sarah B., 580 Enseignement chez les malades (Giroux), 866 Chronic illness, 594 ENURESIS (Tillson), 943 GENERAL duty nurse, orientation of (Koch), Eросн-making news, 22

GENERAL nursing section, 206 HALL, Maude Helen, 452 Portrait, 453 HAMILTON, George H., 748 GERMAIN, Laurentine Etude sur la réhabilitation des anciens tuberculeux, 787 Some medicinal plants, 769 HANSEN, Helen F. GERMAN nursing services (1945-46) (Lawson), 285 Review of nursing (rev.), 392 HARRISON, Dorothy B., 164 GINGRAS, Gustave, 412 Paraplegic patient, 427 Portrait, 177 Progress in Saskatchewan (ed.), 177 GIRARD, Alice (por.), 453 HAYDEN, Vera E., 377 HAYDON, Edith M., Noyes GIROUX, Suzanne Enseignement chez les malades, 866 Manuel des questions et réponses d'exa-mens des gardes-malades (Tassé) Textbook of psychiatric nursing (rev.), (rev.), 477 HEALTH education of the pregnant woman Une question, 951 (Read), 345 GLEADOW, M. E., 332 HEALTH insurance in the United States (Sinai, Anderson, Dollar) (rev.), 721 Up in the air with patients, 363 GONORRHEA — new methods of treatment HEALTH needs of school children, 55 for (Layton), 526 HEALTH problems of an aging population GOODWIN, Christina F. (Philpott), 332 (Hall), 591 Care of the unmarried mother and her HEALTH week (1947), 37 child, 357 HEART disease GORDON, Athol, 908 Nurse in a changing age, 924 GORDON, Ethel May (por.), 455 Bacterial pericarditis (Allbee), 881 HÉBERT, Georges Infirmière et la culture générale, 447 GRADY, Lillian Agnes, 580 HEIDGERKEN, Loretta E Nova Scotia reviews (ed.), 589 Teaching in schools of nursing (rev.), Portrait, 589 GRAHAM, Muriel Jean, 802 GRATION, Hilda M. HENDERSON, Mary E Nursing with UNRRA in Greece, 446 Ward pocket-book for the nurse (rev.). HEPATITIS research, 860 891 HERNIA in infants, 389 GRAY, K. Ethel, 660 HISTORICAL sketch of medicine (Gaum), 58 Leisure years — pleasure years, 706 HISTORY of nursing (Sellew, Nuesse) (rev.), 888 Höjer, Gerda, 660 GRAY, Kenneth George Law and the practice of medicine (rev). 723 Portrait, 681 GREAT Britain: Professional organizations and nurses' Parcels for, 48 working conditions, 682 Hollender, A. R., Snitman
Nursing in eye, ear, nose and throat
(rev.), 222 Royal College of Nursing, 460 V Salary scales for student nurses, 381 Visit to hospitals in, 134 Willesden incident, 303 Holt, Beulah Evelyn, 962 Working party report, summary of, 935 Home-made incubator (Cochran), 220 Green, Edith

Ward pocket-book for the nurse (Gration) (rev.), 891 HOMESTEAD obstetrics (Laycraft), 352 Honey, Elva (Bartsch), 332 Cost analysis of a school of nursing, 367
HOSPITAL and school of nursing section report, 206 GREEN, Paul, 412 Rehabilitation of the paraplegic veteran, HOSPITAL equipment: GREISHEIMER, Esther M. Home-made incubator (Cochran), 220 Physiology and anatomy (rev.), 69 Lit orthopédique (Auxiliatrice), 43 Useful hints (Johnston), 70 GROUP study at the veterans' village (Black), 703 Ward hypodermic tray (Crawford), 142 GUILT and anxiety as social controls (Cam-Hospital housekeeping (Pearston), 187 eron), 107 Hospital management: GUNDRY, Charles H., 828
Public health nurse and mental hygiene, Superintendent does the buying (Bartsch), 861 Hospital penicillin treatment centre (Dé-GUNN, Lynette (por.), 870 cary), 847 Gynecology for nurses (Campbell, Shannon) (rev.), 314 HOSPITAL signalling, 309
HOUGHTON, L. E., Sellors
Aids to tuberculosis for nurses (rev.), 68 HALIFAX Tuberculosis Hospital, 62 HOULISTON, May HALL, Edward, 580 Practice of mental nursing (rev.), 967 Health problems of an aging population, Howard, Ella M. (por.), 57

HULME, Helen (por.), 301 I am a Canadian (ed.), 425

Ice as a local anesthetic, 959

HALL, Gertrude M., 660 I. C. N. congress (1947), 673

Services aux malades, 296

ILLUSTRATIONS of anatomy for nurses JOHNSTON, Georgia F. (Jamieson) (rev.), 476 Useful hints, 70 IMMUNIZATION: JOINT committee-Canadian Hospital Coun-National immunization week, 702 cil and C. N. A., 623 IMPROVISED equipment, in the home care of Jones, Gwyneth Goldsmith, 962 JOSEPH, Sister Thomas Pott's disease, 63 the sick (Olson) (rev.), 889 INCORPORATION—Canadian Nurses' Associa-JOSEPHINE, Sister M.
Nutrition and diet therapy (rev.), 638 INDUSTRIAL dusts can be poisonous, 803 INDUSTRIAL environmental factors, 823 KATHARINE Kent (Gardner), 476 INDUSTRIAL nursing: KEELER, Hazel Eye care (Thompson), 266 Medical education and the changing order Industrial nursing refresher, 886
INFANT and child in health and disease (Zahorsky, Noyes) (rev.), 965 (Allen) (rev.), 148 KEMPF, F. C., Averill Psychology applied to nursing (rev.), 808 INFIRMIÈRE et la culture générale (Hébert), KENNEDY, Margaret Glen (por.), 132 KEY, Barbara (por.), 131 KILPATRICK, Gertrude M. (por.), 803 447 INSTITUTES: Kocн, Mildred, 4 Co-operative refresher course, 884 Orientation of the private duty and gen-Industrial nursing refresher, 886 Instructors' group holds a psychiatric eral duty nurse, 39 institute, 33 KRACKE, ROY R. Color atlas of hematology (rev.), 890 KURTZ, John E., 412 Nurse instructors hold institute, 622 INSTITUTIONAL nursing, committee on, 459 INTERNATIONAL congress of nurses: Role of pathology in cancer control, 437 I. C. N. congress (1947) (Hall), 673 LABOR relations: International education of nurses (Johns), Collective bargaining for nurses, 545 LABOR relations committee, 207, 545 LAKE, Dorothea Nursing groups other than registered nurses (Nothard), 693 Take it off, 34 LAMBERT, Noreen D., 412 Post-graduate education (Mathewson), Orientation program, 441 Professional organizations and nurses' LAMBIE, Mary I., 660 working conditions (Höjer), 682 LANE, Isabel Illustrations of anatomy for nurses (Jamieson) (rev.), 476 Rapport du congrès d'Atlantic (1947) (Allard), 699 LATE cancer case (Young), 195 LAW, Alma F. Student reports on I. C. N. congress (Munro), 713 Annual meeting in New Brunswick, 52 INTERNATIONAL Council of Nurses: LAW and the practice of medicine (Gray) Diagram—organizations, 302 (rev.), 723 Plans for visitors, 198 LAWRENCE, Margaret Program of congress, Rare opportunity, 197 Model nurses' home, 875 LAWSON, Mabel G., 252 INTERNATIONAL education of nurses (Johns), German nursing services (1945-46), 285 Laycock, S. R., 84 INTRODUCTION to psychobiology and psy-Teaching and learning in schools of nurschiatry (Richards) (rev.), 638 ing, 119 Is cancer increasing, 117 ISOLATION technique, a study of (Aitken-LAYCRAFT, Beth, 332 Homestead obstetrics, 352 head), 946 So it's your graduation day, 470 LAYTON, B. D. B., 164, 500 It's not the patient ... it's the visitors (Bell), 277 New methods of treatment for venereal JAEGER, Ellsworth disease — gonorrhea, 526 Easy crafts (rev.), 890 New methods of treatment for venereal JAMIESON, E. B. disease - syphilis, 182 Illustrations of anatomy for nurses LEARNING activities (Stanton), 274 LEBLANC, Suzanne (rev.), 476 JAMISON, Sara Lutte anti-tuberculeuse, 127 Solutions and dosage (rev.), 806 LEDINGHAM, Eula W. (por.), 454 LEESON, H. Jean, 332 JASPER, Herbert H. (Jasper), 84 Electroencephalography, 101 Optimal nutrition for patients, 360 JASPER, Margaret Goldie (Jasper), 84 Electroencephalography, 101 LEGAL aspects of nursing (Lesnik, Anderson), 966 JEANS, P. C., Rand, Blake LEGISLATION committee, 207 Essentials of pediatrics (rev.), 474 Leisure years — pleasure years (Gray), Job analysis (Botsford), 611 706 JOHNS, Ethel, 660 LESNIK, M. J., Anderson

Legal aspects of nursing (rev.), 966

International education of nurses, 686

INDEX TO VOLUME 43

News notes, 154, 226, 320, 401, 479, 565, LETHBRIDGE, Lois, 252 646, 730, 974 Official directory, 240, 488, 736, 984 Personal interview, 293 LEUKEMIA, 928 LEVELTON, Edna Earle Red Cross scholarships, 451 Nurse's prayer (poem), 126 LeWarne, Jane, 580 Care of the chronically ill (Rowe, Wilson), 596 University school, 525 Manitoba's watchtower (Seeman) (ed.), 263 Manuel de l'infirmière visiteuse (N.O.P. H.N.) (rev.), 315 MANUEL des questions et réponses d'exa-LIBRARY housecleaning (Coates), 809 LINDEBURGH, Marion Teaching in schools of nursing (Heidgermens des gardes-malades (Tassé) (rev.), ken) (rev.), 313 477 LIT orthopédique (Auxiliatrice), 43 MARRIAGE and nurses, 903 MARSH, Edith L. LIVING on wheels (Petrie), 432 Livis, Anita Nursing care in chronic diseases (rev.), Traumatic laceration of the ileum, 804 390 LOAN and bursary fund, 547 MARTIN, Lillian E. LUTTE anti-tuberculeuse (Leblanc), 127 Color atlas of hematology (Kracke), 890 McArthur, Helen (MacKay), 164 MARTYN, Florence H., 868 Use of volunteers, 199 MATHEWSON, Mary S., 660 McCullough, Margaret Post-graduate education, 690 Toward a better understanding, 387 MAYBEE, Mildred Ileen, 301 MEAL planning and preparation (Craw-McDonel, Helen M. Professional adjustments (Price) ford), 434 (rev.), 807
McEwen, F. Isobel, 214
McGill School for Graduate Nurses, 287
McHenry, E. W., 164 MEDICAL education and the changing order (Allen) (rev.), 148 MEDICAL services by government (Stern) (rev.), 148 Nutrition in a public health program, 179 MEDICAL-social assistance to nurse war vic-McHose, E., Turner tims, 708 Effective living (rev.), 147 MEDICINAL plants (Hamilton), 769 McIntosh, Margaret, 748 MEDICINE in industry (Stern) (rev.), 69 MEMORIAL at Ottawa, 541 Poliomyelitis, 779 MEMORIAL to the Canadian nursing sisters McKee, Elizabeth, 58 at Ottawa (photo), 542 McPherson, Phyllis MENSTRUATION, the story of, 968 Is cancer increasing, 117 MENTAL hygiene: Guilt and and MACDONALD, Lois anxiety as social controls Review of nursing (Hansen) (rev.), 392 (Cameron), 107 Public health nurse and mental hygiene MACDONALD, Rhoda F. White caps, the story of nursing (Robin-(Gundry), 861 son) (rev.), 808 METROPOLITAN Life Insurance Company MACINTOSH, Eleanor, 748, 828 nursing service, 42, 152, 400, 725, 813, Coramine — a life saver, 774 Trends in nursing, 855 MICROWAVE diathermy, 810 MACKAY, Sheila (McArthur), 164 MILLER, Hazel (por.), 960 Use of volunteers, 199 MITMAN, M. MACLAGGAN, Katherine Food poisoning, 878 Sir Frederick Banting Model nurses' home (Lawrence), 875 (Stevenson) (rev.), 390 Morrison, Pearl L MACLEAN, Jean, 130 Portrait, 131 Nursing care in chronic diseases (Marsh) (rev.), 390 MOTHERWELL, Margaret, 214 MACLEAN, Winnifred Munn, Alexandra (por.), 376 Body mechanics in nursing arts (Fash) (rev.), 147 MACLEOD, Catherine (Richardson), 332 MUNRO, Zeta Student reports on the I. C. N. congress, Cardex system for nurses' orders, 379 713 MacTavish, Jean, 748 MURDOCH, Margaret (por.), 298 Out-patient department as a teaching field, MUSTARD gas studied, 318 Myers, Evelyn, 500 Prostatism, 522 Magnussen, Eli, 206 MALLORY, Evelyn NATIONAL immunization week, 702 Report of meeting of N.L.N.E., 954 NATIONAL League of Nursing Education, MANITOBA: NEILL, Agnes C. Annual meeting in (Fair), 631 Canadian nurses' war memorial, 870 Interim reports of provincial activities, NELSON, Mildred, 84 Manitoba's watchtower (Seeman) (ed.), Psychiatry in the general nursing field, 263

NURSING in China (Preston), 217 Psychology applied to nursing (Averill, NURSING in eye, ear, nose and throat (Hol-Kempf) (rev.), 808 lender, Snitman) (rev.), 222 New Brunswick: NURSING with UNRRA in Greece (Hender-Annual meeting in (Law), 52 Coverage given nurses by the Workmen's Compensation Act, 547 son), 446 NURSING care: Interim reports of provincial activities, Bacterial pericarditis (Allbee), 881 48, 462 Care of the chronically ill (Rowe, Le-News notes, 72, 155, 226, 320, 402, 480, 566, 647, 731, 819, 898, 974 Warne, Wilson), 596 Exploratory laparotomy (Coughlin), 311 Gastric ulcer (Clare), 557 Official directory, 241, 489, 737, 985 New methods of treatment for venereal Pott's disease (Joseph), 63 disease — gonorrhea (Layton), 526 New methods of treatment for venereal Tetanus (Thomson), 144 Traumatic laceration of the ileum (Livis), disease - syphilis (Layton), 182 804 New system of first aid (Clay) (rev.), 722 News notes, 72, 153, 226, 319, 400, 479, 563, 645, 730, 818, 896, 973 NURSING care in chronic diseases (Marsh) (rev.), 390 NURSING care of urologic patients (Caw-NICOLLE, Alice G., 84 ker), 514 Before they see the light of day, 123 NURSING groups other than registered Notes du secrétariat de l'A. I. C., 49, 138, 209, 306, 384, 464, 548, 625, 794, 873, 956 Notes from national office, 45, 133, 205, 303, 381, 459, 544, 623, 709, 791, 871, 953 nurses (Nothard), 693 NURSING Sisters' Association of Canada, 71, 224, 316, 398, 478, 575, 634, 728, 799, 891, 969 Notes on nursing by Florence Nightingale NURSING, trends in (MacIntosh), 855 (rev.), 640 NUTRITION: NOTHARD, C. A., 660 Diet for irritable stomachs, 810 Nursing groups other than registered Dos and don'ts in nutrition, 963 nurses, 693 Education and the public health nurse Nova Scotia: (Crawford), 270 Annual meeting in (Watson), 797 Food models to color, 938 Food poisoning (Mitman), 878 Fried foods, 126 In a public health program (McHenry), Coverage given nurses by the Workmen's Compensation Act, 547 Interim reports of provincial activities, 48, 462 179 News notes, 228, 322, 649, 731, 975 Meal planning and preparation (Craw-Nova Scotia reviews (Grady) (ed.), 589 ford), 434 Official directory, 241, 489, 737, 985 Optimal nutrition for patients (Leeson), Nova Scotia reviews (Grady) (ed.), 589 Noves, A. P., Haydon 360 Salt as sausage preservative, 273 Serving hospital meals attractively (Bell), Textbook of psychiatric nursing (rev.), Noves, E., Zahorsky Vitamin C in potatoes, 934 Infant and child in health and disease Vitamin lack affects eyes, 877 (rev.), 965 Nuesse, C. J., Sellew History of nursing (rev.), 888 NUTRITION and diet therapy (Proudfit, Robinson) (rev.), 638 NUTRITION education and the public health NURSE and cancer control (Smith), 28 NURSE in a changing age (Gordon), 924 nurse (Crawford), 270 NUTRITION in a public health program (Mc-NURSE-patient relationships in psychiatry Henry), 179 (Render) (rev.), 967 OBITUARIES: NURSE war victims, medical-social assistance to, 708 Acres, Frances Adelaide, 38 Argue, Elizabeth, 456 NURSES' aides Barton, Dorothy M., 378 Aide ou auxiliaire en Manitoba (Waugh), Bath, Carrie E. (Coleman), 963 373 Baudry, Yvonne, 216 Beard, Mary, 308 Bell, Jean Isabel, 705 Bell, Jessie, 963 Betts, Ella, 216 Nursing groups other than registered nurses (Nothard), 693 Registre Ville-Marie (Robert), 203 Services aux malades (Hall), Training nursing assistants (Riddell), 851 Bibby, Blanche, 556 Women volunteer to aid hospitals (Cour-Bresnan, Patricia, 456 lander), 717 Brown, Elsie Maude (Bickell), 378 NURSES' orders, Cardex system for (Ri-Buckland, Hazel (Darker), 865 Campbell, Katharine Grace, 610 chardson, MacLeod), 379 Nurse's prayer (poem), 472 Carter, Mary Ann, 308 Carter, Maud, 378 Chadsey, Enid Lenore, 556 Nurse's prayer (poem) (Levelton), 126

Clapp, Martha Jane (Marriott), 786

NURSES textbook of anatomy and physi-

ology (Spencer) (rev.), 221

Clarkson, Estella M., 456 Coburn, Agnes, 805 Colley, Georgina Henrietta, 308 Conklin, Christina Ann, 610 Conley, Isabell (Gourdier), 309 Cook, Mrs. James, 309 Crane, Belle (O'Reilly), 456 Cressman, Lydia, 456 Davidson, Helen Joyce, 38 Dawkins, Alice Cecil K., 456 Portrait, 457 Debonardi, Alverna, 963 Denonardi, Alverna, 963
Dunlop, Edythe (Cates), 456
Eltherington, Mrs. A. W. (Hunter), 963
Enright, Nellie Josephine, 457
Fenwick, Mrs. Bedford, 378
Fillmore, Maria, 38
Francis, Mary M. (Ray), 786
Franey, Marie, 378
Fraser, Sarah, 216
Graham, Long. 278 Graham, Lena, 378 Grant, Hannah J. (Cody), 963 Hall, Lily deVeer, 378 Hamblin, Rowena, 610 Hamilton, Josephine, 38 Henderson, Anne Charlotte, 378 Horner, Alida M., 309 Howes, Mary Isabel, 143 Howitt, Kathleen (Twiss), 378 Hushin, Theresa, 378 Hyde, Doris E., 457 Idington, Flora C., 309 Johnson, Carolina, 610 Jordan, Thyra B., 378 Jouin, Sister Françoise, 705 Jouin, Sister Françoise, 705
Kane, Lucy (Dunlop), 378
Kerr, Kate (Johnson), 378
Kilgour, Mary Martha, 610
Knight, Kathleen M., 143
Knowles, Lylian Audrey (Hurd), 865
Lane, Etta Naomi, 378
Laporte, Yvette, 963
Lumby, Mary Pearl, 143
McCausland, Edith, 865
McGilvray, Margaret Campbell, 705
McKeown, Margaret Florence, 143
McLain, Frances (Pollard), 216 McLain, Frances (Pollard), 216 McRitchie, Christine Bell, 309 MacDuff, Margaret (Telfer), 457 MacGregor, Idella Gertrude, 378 MacKay, Christy A., 865 Martha, Sister Mary, 143 Mathieson, Kate (por.), 457 Mathieson, Kate (por.), 457
Milhim, Mrs. Fred, 556
Miller, Lila Jennings, 216
Miller, Nellie, 556
Moralce, Adah, 458
Morgan, Lucy D., 786
Morin, Lucy Marguerite, 379
Morkill, Velma (Coote), 865
Moulds, Ethel G. (Sm'th), 216
Murray, Jean Grant (Brodie), 143
Parks, Mrs. Hugh (Bell), 963
Parnall, Nellie Maud (Gadsby), 143
Rand, Olive Young, 38 Rand, Olive Young, 38 Robinson, Jessie Wood, 556 Ross, Eva A., 865 Rowan, Georgie L. (por.), 458 Ryan, Mabel, 216

Schofield, Georgie (Collins), 458 Schwalm, Laura A., 786 Selley, Doris, 143 Sharp, Katherine S., 705 Shearman, Mary Margaret, 379 Sims, Adelaide, 379 Slykhuis, Mrs. William (Pickering), 458 Smyth, Florence (Bouck), 309 Spence, Catherine Frances, 379 Stanton, Kathleen Mary, 379 Taylor, Jessie Penelope (Bonnor), 786 Tobin, Lillian, 216 Tobin, Lillian, 216
Turner, Hannah Gertrude, 705
Wallace, Elizabeth (Allen), 458
Walsh, Helen Mary, 705
Warren, Jane, 610
Welsh, Dorothea Jean (Spratt), 309
Wilkins, Enid, 143
Williams, Alice, 786
Wilson, Edythe Louise, 458
Zimmerman, Marganet, 38 Zimmerman, Margaret, 38 **OBSTETRICS**: Delivery room technique (Armstrong), Health education of the pregnant woman (Read), 345 Homestead obstetrics (Laycraft), 352 Prenatal classes (Black), 703 OCCUPATIONAL therapy for the chronically ill (Driver), 602 Official directory, 80, 160, 239, 328, 408, 487, 576, 656, 735, 824, 904, 983
Ogilvie, Sheila, 908 Recreation for student nurses, 933 OLSON, Lyla M. Improvised equipment, in the home care of the sick (rev.), 889 ONTARIO Annual meeting in (Fitzgerald), 54, 631 Appointments, transfers, resignations, 42, 151, 224, 317, 478, 644, 725, 814, 892 Interim report of provincial activities, 462 News notes, 72, 155, 229, 322, 402, 481, 566, 649, 819, 898, 976 Official directory, 241, 489, 737, 985 Ontario seeks new nursing bill (Fidler) (ed.), 759 Ontario seeks new nursing bill (Fidler) (ed.), 759 Operating-room experience for the student nurse (Adams), 370 OPTIMAL nutrition for patients (Leeson), 360 ORGANIZING a well baby clinic (Douglas), ORIENTATION of nurses (Street), 533 ORIENTATION of the private general duty nurse (Koch), 39 ORIENTATION program (Lambert), 441 ORR, Margaret Orthopedic nursing (Funsten, Calderwood) (rev.), 392 ORTHOPEDIC nursing (Funsten, Calderwood) (rev.), 392 Our own page (Schumacher), 201 Our threatened values (Chittick) (ed.), 21 Our-patient department as a teaching field

(MacTavish), 776

Our-patient experience, my (Thomas), 635

Outpost nursing — a challenge to Canadian Official directory, 242, 490, 738, 986 nurses (Schonberg), 615 Public health nursing in (Wheler), 289 PAMPANA, E. J. Princess weds (ed.), 838 PRIVATE duty nurse, orientation of (Koch), Resuscitation of the drowned, 560 PARAPLEGIA: Living on wheels (Petrie), 432 PRIVATE duty nursing: It's not the patient...it's the visitors (Bell), 277 Paraplegic patient (Gingras), 427 Rehabilitation of the paraplegic veteran (Green), 431 Private duty nursing, committee on, 459 PARAPLEGIC patient (Gingras), 427 PARKINSON, Roy H. PRIZE winners, 42 Profession — definition of, 882 Eye, ear, nose and throat manual for nurses (rev.), 314 Professional adjustments I (Price) (rev.). 807 PATERSON, Norman M. (por.), 512 Professional adjustments in nursing (Spald-PATHOLOGY, role of, in cancer control (Kurtz), 437
Pearson, Virginia ing) (rev.), 222 Professional organizations and nurses' working conditions (Höjer), 682 Physiology and anatomy (Greisheimer) Progress in Saskatchewan (Harrison) (ed.), (rev.), 69 Pearston, Elizabeth, 164 PROSTATISM (Myers), 522 PROUDFIT, F. T., Robinson Hospital housekeeping, 187 PEDIATRICS: Nutrition and diet therapy (rev.), 638 Providing the keys (ed.), Organizing a well baby clinic (Douglas), 36 Provisional council, 129 Pre-school classes, 703 Penhale, Helen E., 908 PSYCHIATRIC affiliation (Smith), 114 PSYCHIATRY: Expansion of clinical facilities, 948 Psychiatric affiliation (Smith), 114 Psychiatry in the general nursing field (Nelson), 111 PENICILLIN treatment centre (Décary), 847 PERCY, Dorothy May (por.), 212 PERSONAL interview (Lethbridge), 293 Shock therapy (Fisher), 839 Personnel guidance (Rowles), 863 PSYCHIATRY in the general nursing field Personnel policies: (Nelson), 111 Psychology applied to nursing (Averill, Job analysis (Botsford), 611 Kempf) (rev.), 808 Orientation of nurses (Street), 533 Orientation program (Lambert), 441 Personal interview (Lethbridge), 29 Psychology of growth (Beverly) (rev.), 640 Public health nurse and mental hygiene Personnel guidance (Rowles), 863 (Gundry), 861 Transfers, discharges, and methods of resigning (Beatrice), 783 Public health nursing, committee on, 459 Public health nursing in Prince Edward PETRIE, D. George, 412 Island (Wheler), 289 Living on wheels, 432 Public relations Pettigrew, Lillian (por.), 868 Philpott, N. W. (Goodwin), 332 Start talking (Campbell), 844 Publicity committee, 208 Care of the unmarried mother and her PULLAN, Edith Introduction to psychobiology and psychild, 357 chiatry (Richards) (rev.), 638 Physiology and anatomy (Greisheimer) (rev.), 69 QUEBEC: POLIOMYELITIS (McIntosh), 779 Annual meeting in (Upton), 798 Poliomyelitis, paralysis in, 720 Interim reports of provincial activities, 48, 462 POPE, Cecilia Improvised equipment, in the home care News notes, 76, 155, 232, 481, 570, 650, 731, 899, 978 of the sick (Olson) (rev.), 889 Post-graduate education (Mathewson), 690 Official directory, 242, 490, 738, 986 Poster competition, 789, 910 OUEBEC Nurses Act. 462 RACEY, Martha Rose (por.), 456 Port's disease (Joseph), 63 RADIOACTIVE isotopes, 366 Practical importance of the Rh factor RAND, W., Jeans, Blake (Denton), 23 PRACTICAL nursing (rev.), 475 Essentials of pediatrics (rev.), 474 RAPPORT du congrès d'Atlantic City (1947) Practical side of evaluation (Blackall), 939 PRACTICE of mental nursing (Houliston) (rev.), 967 (Allard), 699 RAYMOND, Patricia PRESTON, L. Clara Essentials in pediatrics (Jeans, Rand, Blake) (rev.), 474 Nursing in China, 217 PRICE, Alice L. REA, Joyce, 790 Professional adjustments I (rev.), 807 READ, Grantly Dick, 332 PRINCE Edward Island: Health education of the pregnant woman, Interim reports of provincial activities, 48, 462 RECREATION for student nurses (Ogilvie),

News notes, 231, 819

REGISTRE Ville-Marie (Robert), 203 Schonberg, Muriel I., 580 Outpost nursing - a challenge to Canadian Rehabilitation of the paraplegic veteran nurses, 615 (Green), 431 RENDER, Helena W Nurse-patient relationships in psychiatry (rev.), 967 RESUSCITATION of the drowned (Pampana), 560 Bartsch), 367 REVIEW of nursing (Hansen) (rev.), 392 RH factor — practical importance of (Denton), 23 RICHARDS, Esther L. Introduction to psychobiology and psychiatry (rev.), 638 RICHARDSON, Isabel (MacLeod), 332 Cardex system for nurses' orders, 379 RIDDELL, Dorothy G., 828 Training nursing assistants, 851 RIDDELL, Lois Frost-bite, 964 RIORDAN, Aileen History of nursing (Sellew, Nuesse) (rev.), 888 ROBERT, Anne-Marie Registre Ville-Marie, 203 ROBINSON, C. H., Proudfit Portrait, 802 Nutrition and diet therapy (rev.), 638 ROBINSON, Victor White caps, the story of nursing (rev.), 808 Rocque, Emma (por.), 455 (rev.), 721 ROGERS, E. Bell Annual meeting in Alberta, 626 390 Role of pathology in cancer control (Kurtz), 437 ROSENTHAL, H., Stern, Rosenthal Diabetic care in pictures (rev.), 69 ROSENTHAL, J., Rosenthal, Stern Diabetic care in pictures (rev.), 69 Rowe, Edith, 580 Care of the chronically ill (LeWarne, Wilson), 596
Rowles, C. E. M., 42, 164, 828 Bedside nursing — an essential service, 190 Personnel guidance, 863 Soeurs Grises Portrait, 190 RUANE, Winnifred (rev.), 967 Medicine in industry (Stern) (rev.), 69 RUNDLE, Mildred V Baffin Land - the place of the buck deer, 66 Russell, Marjorie Gordon, 960 Portrait, 961 SANDELL, Ada (por.), 132 SASKATCHEWAN: Annual meeting in (Ellis), 632 SPENCER, A. M. Appointments, transfers, resignations, 151 Coverage given nurses by the Workmen's Compensation Act, 547 Fees for private duty nurses, 463 Interim reports of provincial activities, 48, 463 News notes, 76, 156, 233, 324, 403, 482, 570, 651, 820, 899, 979 Official directory, 242, 490, 738, 986 Progress in Saskatchewan (Harrison)

(ed.), 177

Schedule of minimum salaries, 463

SCHOOL health work: Before they see the light of day (Nicolle). Meeting health needs of school children, 55 School of nursing, cost analysis of (Honey, SCHUMACHER, Marguerite E., 164 Our own page, 201 SCOTT, W. B. (por.), 513 SEEMAN, Beryl, 252 Manitoba's watchtower (ed.), 263 Manifold & Water Conference of the Conference of Aids to tuberculosis for nurses (rev.), 68 Services aux malades (Hall), 296 Serving hospital meals attractively (Bell), SHANNON, M. A., Campbell Gynecology for nurses (rev.), 314 Shepherd, Mary Lillian, 801, 908 Communicable disease techniques, 929 Sноск therapy (Fisher), 839 SHORTAGE of nurses, 696 SINAI, N., Anderson, Dollar Health insurance in the United States SIR Frederick Banting (Stevenson) (rev.), SMELLIE, Elizabeth L., (por.), 452 SMITH, Alice K., 4 Nurse and cancer control, 28 SMITH, Ella G., 84 Psychiatric affiliation, 114 Textbook for psychiatric attendants (Fitzsimmons) (rev.), 721 SNITMAN, M. F., Hollender Nursing in eye, ear, nose and throat (rev.), So it's your graduation day (Laycraft), 470 Soin des malades, principes et techniques Soin des malades, principes et techniques (Soeurs Grises) (rev.), 967 Solution must be found (Agnew), 696 Solutions and dosage (Jamison) South African nurses visit Canada, 712 SPALDING, Eugenia K. Professional adjustments in nursing (rev.), Nurses textbook of anatomy and physiology (rev.), 221 Stanton, Kathleen M., 252 Learning activities, 274 START talking (Campbell), 844 STERN, Bernhard J. Medical services by government (rev.). Medicine in industry (rev.), 69 STERN, F., Rosenthal, Rosenthal Diabetic care in pictures (rev.), 69

STEVENSON, Lloyd Sir Frederick Banting (rev.), 390 STEWART, Isabel Maitland (por), 800 SIEWART, Mary Summary of medicine for nurses (Cooke) (rev.), 221 STIVER, Pearl, 412 They too are our patients, 443 STORY, Marion C. (por.), 131 STREET, Margaret M., 500 Orientation of nurses, 533 adjustments Professional 272 mursing (Spalding) (rev.), 222 STUART, Eugenie Margaret (por.), 960 STUART, Hilda Muir, 962 STUDENT nurse and chronic illness (Connor) 599 STUDENT nurse affiliation: Psychiatric affiliation (Smith), 114
STUDENT reports on the I.C.N. congress (Munro), 713 STUDY of isolation technique (Aitkenhead), Subscription rates, 463 SUMMARY of medicine for nurses (Cooke) (rev.), 221 SUPERINTENDENT does the buying (Bartsch), SUTHERLAND, Agnes Young, 962 Syphilis - new methods of treatment for (Layton), 182 TAKE it off (Lake), 34 TASSÉ, Charlotte Manuel des questions et réponses d'examens des gardes-malades (rev.), 477 TATE, Dorothy Medical services by government (Stern) (rev.), 148 TAYLOR, Effic (por.), 681 TAYLOR, Madeline (por.), 212 TEACHING and learning in schools of nursing (Laycock), 119 TEACHING in schools of nursing (Heidger-ken) (rev.), 313 TEACHING methods: Group study at the veterans' village (Black), 703 Learning activities (Stanton), 274 Teaching and learning in schools of nursing (Laycock), 119 TENNANT, Margaret American hospital (Corwin) (rev.), 221 TEXTBOOK for psychiatric attendants (Fitzsimmons) (rev.), 721
Textbook of psychiatric nursing (Noyes, Haydon) (rev.), 222 Textiles, new, 196 THEY too are our patients (Stiver), 443 THOMAS, Florence Textbook of psychiatric nursing (Noyes, Haydon) (rev.), 222 THOMAS, Helen My out-patient experience, 635 Thompson, Charles A., 252 Eye care, 266 Thomson, Jacqueline Tetanus, 144

THORMAN, George

Toward mental health (rev.), 392

THESON, Nora, 908 Enuresis, 943
Toward a better understanding (McCullough), 387 Toward mental health (Thorman) (rev.). Training nursing assistants (Riddell), 851 Transfers, discharges, and methods of resigning (Beatrice), 783 TRAUMATIC laceration of the ileum (Livis), 804 TRENDS in nursing (MacIntosh), 855 TUBERCULOSIS Anti-tuberculosis survey, 718 Emploi du B.C.G. (Badeaux), 537 Etude sur la réhabilitation des anciens tuberculeux (Germain), 787 Etude sur une affiliation dans sanatorium de tuberculeux, 619 Lutte anti-tuberculeuse (Leblanc), 127 Pott's disease (Joseph), 63 Segregation of tuberculosis patients, 734 TURNBULL, Ailsa (por.), 300 TURNER, C. E., McHose Effective living (rev.), 147 UNDERHILL, Bernice Charlotte, (por.), 961 UNE question (Giroux), 951 University schools of nursing, enrolment in, 283 UNMARRIED mother and her child, care of (Philpott, Goodwin), 357 UP in the air with patients (Gleadow), 363 UPTON, E. Frances Annual meeting in Quebec, 798 UROLOGY: Nursing care of urologic patients (Caw-ker), 514 Prostatism (Myers), 522 Use of the volunteer worker in a public health nursing service (Barr), 35 Use of volunteers (McArthur, MacKay), 199 Useful hints (Johnston), 70 VACATION thoughts (ed.), 511 VANCOUVER Metropolitan Health Committee, 815 VENEREAL disease: Blood test survey, 782 New methods of treatment for venereal disease — gonorrhea (Layton), 526 New methods of treatment for venereal ·disease — syphilis (Layton), 182 They too are our patients (Stiver), 443 VICTORIAN Order of Nurses for Canada: Annual meeting, 633 Appointments, transfers, resignations, 41, 152, 317, 816, 893 VISIT to hospitals in Great Britain, 134 VOLUNTEERS: Use of the volunteer worker in a public health nursing service (Barr), 35 Use of volunteers (McArthur, MacKay), 199 VOLUNTEERS, the use of (McArthur, Mac-Kay), 199 WAR memorial trust fund, 38, 439, 562, 614, 789, 828, 969 WAR victims, medical-social assistance to nurse, 708

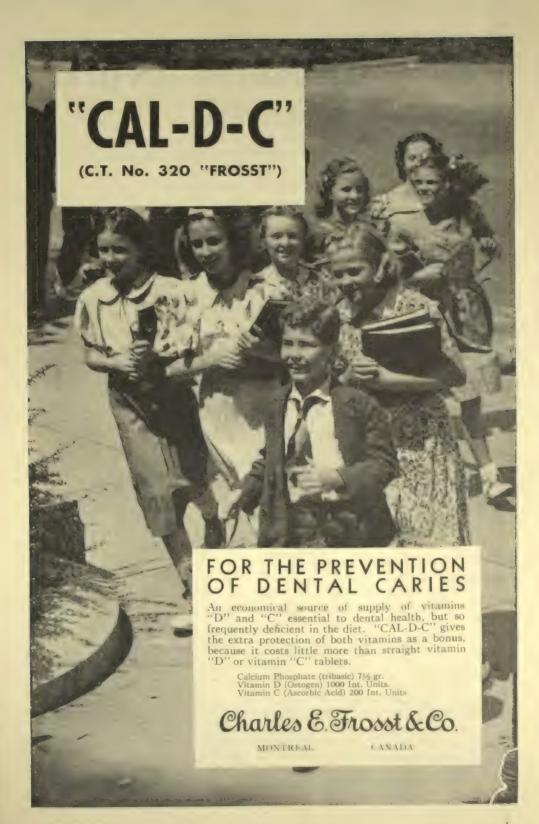
INDEX TO VOLUME 43

WARD, Dorothy Maxine (por.), 130 WARD hypodermic tray (Crawford), 142 WARD pocket-book for the nurse (Gration) (rev.), 891 WATSON, Nancy H. Annual meeting in Nova Scotia, 797 WAUGH, Frances, 332 Aide ou auxiliaire en Manitoba, 373 Weir, Jenny McMartin (por.), 868 What is a profession, 882
Wheler, Eleanor R., 252
Public health nursing in Prince Edward Island, 289 "WHERE we gone" (ed.), 919 White caps, the story of nursing (Robinson) (rev.), 808
Why I choose nursing (Capelle), 777 Why immunize, 702 WICKLUND, Ellen C. (por.), 962 WIGHTMAN, Phyllis, 869 WILLESDEN incident, 304 WILSON, Elsie J. Aids to tuberculosis for nurses (Houghton, Sellors) (rev.), 68

Wilson, James and Florence Legal aspects of mars no (Lesnik, Anderson) (rev.), 966 Wilson, Jessie, 580 Care of the chronically ill (Rowe, Le-Warne), 596 WITH UNRRA in Germany (Creelman), 532, 605, 710 Women volunteer to aid hospitals (Courlander), 717 Working party report, summary of, 935 Workshops for nurses, 791 World health organization: functions, 133 WRIGHT, Alice L. Annual meeting in British Columbia, 628 WRIGHT, Anne (por.), 376 YAHOLNITSKY, Pauline (por.), 299 Young, George S. Late cancer case, 195 ZAHORSKY, J., Noyes
Infant and child in health and disease (rev.), 965







The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR JANUARY, 1947

OUR THREATENED VALUES	21
EPOCH-MAKING NEWS.	22
THE PRACTICAL IMPORTANCE OF THE RH FACTOR	
THE SUPERINTENDENT DOES THE BUYING	25
THE NURSE AND CANCER CONTROL	28
THE USE OF THE VOLUNTEER WORKER IN A PUBLIC HEALTH NURSING SERVICE, K. Barr	35
ORGANIZING A WELL BABY CLINIC	36
ORIENTATION OF THE PRIVATE DUTY AND GENERAL DUTY NURSE	39
LE LIT ORTHOPÉDIQUE	43
Notes from National Office	45
Notes du Secrétariat de l'A.I.C.	49
Provincial Annual Meetings	52
Interesting People	56
$\label{thm:model} \mbox{Historical Sketch of Medicine}$	58
POTT'S DISEASE	63
Letters from Near and Far	66
Book Reviews	68
NURSING SISTERS' ASSOCIATION OF CANADA	71
Your Ware	P2 (3)

Subscription Rate: \$2.00 per year—\$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, \$1.50 per year; eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 11 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.Q.

2 New Lippincott Nursing Texts!

Heidgerken • Teaching in Schools of Nursing • PRINCIPLES & METHODS

New Book!

By Loretta E. Heidgerken, R.N., M.S., Assistant Professor of Nursing Education and Supervisor of Field Experience in Teaching, The Catholic University of America, Washington, D.C.

A New book on competence in teaching, with the spark of greatness... motivates self activity to develop inspirational teaching and a taste for more knowledge... an unusual text for students of teaching... a guide for all nurses. Miss Heidgerken presents the principles and practice of successful teaching for everyday usage; objectives, conditions and environment of the learning process... planning and organization of learning activities... instruction methods... the use of audi-visual aids, and guiding factors in self evaluation. Purposeful activity is the keynote of this stimulating text — activity that results inevitably in a new concept of nursing care.

478 Pages

Illustrated

\$4.50

Marsh · Nursing Care in Chronic Diseases

New Book!

By Edith L. Marsh, R.N., S.C.M., Superintendent, Cuyahoga County Nursing Home, Cleveland, Ohio. An excellent New book thoroughly outlining the enlightened care needed in nursing the chronic patient in any age group. The author clearly interprets the special skills required for nursing the most common chronic disease states. The text is rich in case history. The subjects covered include nursing care for Heart Disease; Arthritis; Multiple Sclerosis and Muscular Dystrophy; Paralysis, Parkinson's Disease, Chorea, Central Nervous System Lues and Diabetes; the Chronically ill Service Man; Psychiatry in Nursing Care; Diet and Nutrition; Physical and Occupational Therapy.

237 Pages

Illustrated

Tent. \$3.25

CN1-47

1	R	LIPPINCOTT	COMPANY	Medical Arts	Building	Montreal 2	5 PQ

Enter my order and send me:

A.R.	ON DUTY
W. NUR	
SING	WAG ST

Heidgerken —	Teaching in S	schools of Nursi	ing — \$4.50		
Marsh - Nursin	g Care in Cl	nronic Diseases	-Tentative	price -	\$3.25
Cash Enclose	d 🗍	Send C.O	.D.		

Name....

Street.

LIPPINCOTT NURSING TEXTS

IANUARY, 1947

Reader's Guide

Greetings to all of our readers in this the first number of Volume 43! The months roll past so quickly that it scarcely seems possible it is twelve of them since we opened the last volume. The entire staff at your *Journal* office unite in hoping that 1947 will be a splendid year for each one of you. We hope that as each day unfolds it will reveal new joys, new successes and, above all else, a step nearer to the peace and security for which each of us yearns.

It is customary for the president of the Canadian Nurses' Association to write the lead article for the New Year's issue of the Journal. Each of our presidents has been a very busy woman in her own position with the demands and responsibilities of her work in our national association superimposed. When they take time out to write for us they always have a message that is well worth reading. Rae Chittick has given us a challenge which we must not shirk if we would be true to our calling. Our responsibility as nurses goes beyond caring for the physical needs of our patients. Do not miss reading this editorial.

Maternal and neonatal mortality are matters of serious concern. Many of these deaths seemed without a known cause. Today, our research scientists have demonstrated that some of these mothers and babies may be lost because of the mixing of antagonistic blood elements—the Rh factors. R. L. Denton, B.Sc., M.D.C.M., who has described how this comes about, is Director of the Department of Hematology at Children's Memorial Hospital, Montreal, after taking special courses in this work at Harvard. Dr. Denton is also Director of the Blood Banks at the D.V.A. hospitals in the Montreal area.

Though their undergraduate training gives them an insight into the rate at which hospital supplies are used, and though some of them have had post-graduate courses in hospital administration, every nurse who finds herself confronted with the responsibility of doing the purchasing for her hospital has qualms as to whether or not she is going about the job in the right way. Hilda Bartsch, from her years of experience as superintendent of the

Victoria Public Hospital, Fredericton, N.B., gives sound advice which will help the novice over many rough spots.

One of the most active lines of medical research today is the attempt to find the cause of cancer. Coupled with this is a pressing need to make all of our people aware of the facilities that are available for controlling and curing this disease. One of the most useful avenues of education is the nursing profession yet few nurses know all of the facts. The Canadian Cancer Society has undertaken to assist us with the task of supplying this information through a series of regular releases. Alice K. Smith, R.N., the author of our first article, is associated with the Manitoba Cancer Relief and Research Institute. This series will appear regularly throughout this year.

A great many nurses return to their own hospitals to work after graduation but there are some who yearn for distant fields. Whether they engage in private duty or in general staff work, they feel somewhat at a loss as they enter a strange hospital. "Where do we go from here?" is a typical reaction. Mrs. Mildred Koch, of Winnipeg, has given us some suggestions, which, if adopted by our hospitals, would smooth out many of these problems.

Volunteers have been used in hospitals and in public health agencies for many years now. Katherine Barr has assessed the value of the contribution that they have made to the work of an official agency. Miss Barr is with the nursing division of the Winnipeg Health Department.

Preview

We often speak, more or less facetiously, about having a "brain wave" indicating that we are planning some new or varied pattern of behavior. Next month we are bringing you an authentic account of the technique for measuring the electrical impulses in the brain by means of electroencephalography. Dr. Herbert H. Jasper and Margaret Goldie Jasper have explained it simply enough that we can all understand its value for certain forms of diagnosis.

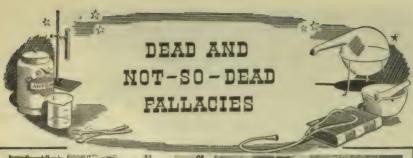


We all know that it takes more time and effort to make anything better. Seventy

oped to insure the quality, purity, uniformity, and fast disintegration of genuine "Aspirin" tablets.

"ASPIRIN"

JANUARY, 1947





For several generations, persons with burns thought that they were getting effective treatment if they held the injured part before a fire. This was supposed "to draw out the inflammation."



Equally unscientific is the belief of many modern folk that it is not safe to leave food in open cans. Actually, according to the U. S. Department of Agriculture, the food is just as safe in open cans—when kept cool and covered.



AMERICAN CAM

AN COMPANY
TORONTO VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

-a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

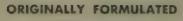


AMERICAN CAN COMPANY Medical Arts Building, Hamilton, Ont. Please send me the new Canadian edition of "THE CANNED FOOD REFERENCE MANUAL," which is free.

Professional Title.....

Address

City.....Province..



FOR

DOCTORS AND NURSES

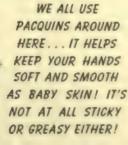
• Yes...Pacquins Hand Cream was originally formulated for doctors and nurses. You see, what with thirty to forty soapywater scrubbings a day, your hands take a real beating in a hospital. You need a cream super-rich in humectant (the skin-softening ingredient) . . . and Pacquins is just that! Ask for Pacquins at any drug, department, or ten-cent store.

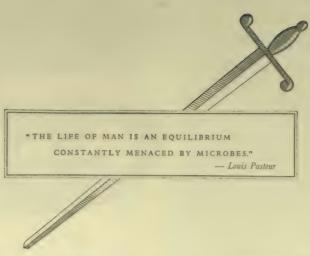






SAY... YOU WERE A PEACH TO TELL ME ABOUT PACQUINS. THIS SCRUBBING USED TO LEAVE MY HANDS SO RED AND ROUGH! BUT PACQUINS FIXED THAT!





The use of 'Dettol' in concentrated form is not prohibited by toxic effects. A 2 per cent solution very rapidly kills haemolytic streptococci and *B.coli*, even in the presence of pus.

AN ANTISEPTIC which was both efficient in dilution and safe at full strength, one which tremendously widened the margin between the clinically effective and the toxic dose, was bound, from the outset, to command the closest, liveliest interest. And so, ever since its first introduction, some ten years ago, to the British Medical profession, 'Dettol' has been submitted to the test of vast clinical experience. Its performance, recorded not only in scientific papers but in standard text-books, today influences both opinion and practice throughout the British Empire.

A HIGHLY-EFFICIENT germicide, non-poisonous, stable, active in the presence of blood and pus, deodorant, pleasant in smell, nonstaining to linen and the skin, 'Dettol' is clearly indicated for use in all those contingencies which call for unfailingly effective, safe and pleasant antisepsis. 'DETTOL' OBSTETRIC CREAM is a preparation of 30 per cent 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against re-infection.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL, M. 13



Treat your hands to TRUSHAY

When hands are rough, the skin dry and cracked, there's not only the discomfort to consider—there's the danger of infection.

Before washing with soap and water, also before exposure to alcohol, antiseptics and other skin-drying agents, use TRUSHAY.

Creamy, peach-colored TRUSHAY guards against depletion of the skin's natural lubricant...helps keep the dermal tissue normal and unbroken. You'll be delighted with the fragrant softness that TRUSHAY gives hands and arms.

Bed-weary patients, too, appreciate a rub with TRUSHAY. It helps prevent pressure sores.

TRUSHAY

THE "BEFOREHAND" LOTION

A Product of BRISTOL-MYERS COMPANY

of Canada, Ltd.

3035-NM St. Antoine St., Montreal 30, Canada





ONLY Sitty's Baby Foods are HOMOGENIZED



LIBBY'S PROCESS OF HOMOGENIZATION

- Opens cell capsules, releases contained nutriment, and disperses it homogeneously throughout.
- Comminutes indigestible cell membranes and coarse cellulose fibres.
- Exposes the nutriment to the digestive juices in a considerably increased surface area, thus facilitating digestion.
- Increases availability of the contained nutrients, thus facilitating utilization.
- Renders cellulose mechanically bland, without impairing physiologic effect of bulk on intestinal motility.

Homogenization removes indigestible factors

While authorities agree that the addition of solid foods to the infant's milk diet at the earliest possible age is sound nutritional practice, many doctors have hesitated to prescribe them during the early months of infancy because of the danger of gastro-intestinal disturbances caused by coarse vegetable fibres, and of the passage of incompletely digested food into the large intestine. Libby's patented Homogenization process which explodes food cells and comminutes vegetable fibres overcomes both these objections. Clinical tests have demonstrated that when Libby's Homogenized Baby Foods are added to the diet as early as the second month, they cause no gastrointestinal disturbance, and they supply valuable food elements not supplied by milk, notably iron and certain vitamins. Because only Libby's Baby Foods are Homogenized, only with Libby's can this additional nutrient required for

optimal nutrition be made available so early in life without the risk of digestive upsets.



REPORTS ON CLINICAL AND LABORATORY STUDIES WILL BE SENT ON REQUEST

BFM-6-46

LIBBY, McNEILL AND LIBBY OF CANADA, LIMITED, CHATHAM, ONTARIO

Vol. 43. No. 1



BETTER PSYCHOLOGICAL MANAGEMENT OF CATAMENIA



While a woman (during her menses) may reluctantly accept the sense of depression, nervous tension, and in-

creased irritability towards her surroundings as inevitable, she will still be grateful for any suggestion that may ease her burden.

By recommending TAMPAX you can help your patient's emotional attitude towards menstruation by pointing out that (differing from pads) TAMPAX provides

- ... complete INTERNAL protection
- ... freedom from perineal irritation
- ... prevention of objectionable odor

You can assure your patients that many women scarcely notice the presence of TAMPAX—it is so comfortable to wear.

To meet the varying requirements of the individual, TAMPAX is available in "Super", "Regular", and "Junior" absorbencies. The coupon below is for your convenience.

TAMPAX

FOR BETTER PROTFCTIVE MANAGEMENT

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

 OF THE AMERICAN MEDICAL ASSOCIATION
Canadian Tampax Corporation Ltd., Brampton, Ontario.
Please send me a professional supply of the three absorbencies of Tampax—together with literature.
Name (Please Print)
Address

JANUARY, 1947



Your Newest Patients Appreciate Foods with

Fine Flavour, Colour, Texture

PRESCRIBE HEINZ BABY FOODS FOR THEIR ENJOYMENT

Nobody knows, better than the doctor does, the importance of starting baby on foods which have appealing flavour, colour and texture. Heinz Baby Foods rate high on all three counts. And they're backed by one of the oldest and finest quality traditions in the food industry.



HEINZ BABY FOODS





FREE TO DOCTORS, NURSES AND DIETICIANS—Nutrition Charts and data on Infant Feeding and Strained Foods. For free copies write H. J. Heinz Company of Canada Ltd., 420 Dupont Street, Toronto, Ontario

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER ONE

MONTREAL, JANUARY, 1947

Our Threatened Values

ONE CANNOT BEGIN a New Year without looking back at the old, for it is by consideration of the past that we build our plans for the future. Reflection on the tragedies of the last few years brings one to the conclusion that there are two kinds of damage in war: the visible and the invisible. The visible damage in the war just concluded was appalling—a tremendous loss of life and property. But the invisible damage, perhaps, was worse—the loss of human values which constitute the foundation of our whole society.

We, as members of the nursing profession, must concern ourselves with two of these values—firstly, the dignity of the individual, and, secondly, his responsibility. Both of these values have emerged from the war perceptibly weakened, and many thoughtful people are asking whether they can even survive.

The idea of individual dignity implies respect for one's own personality and that of others. Victor Gollancz says in his recent book, "Our Threat-

ened Values," that respect for the human personality is the greatest value of all. This respect does not necessarily mean admiration or approval for every person—our feelings are often just the opposite—but it does mean the recognition of every person's basic rights as a human being, an individual.

Mr. Gollancz points out: "When we say that we respect personality, we mean that we recognize in every human being something special, particular, concrete, unique—something in its own right."

During the war, we lost sight of this. We had not time to think of the individual and his right: we thought of people in groups and masses. Those who belonged to one particular group were human, and had rights; those who belonged to another group were inhuman, and had none. This attitude is inevitable in war, but unless it is overcome in peace it will undermine the whole foundation of civilization.

As for the sense of individual responsibility you have marked, with

JANUARY, 1947

your own eyes, its great deterioration during the last few years. People have become accustomed to laying the blame somewhere else, placing the responsibility somewhere else, looking for help and guidance somewhere else. There is a widespread tendency not to set one's own standards, but to follow the standards set by others: not to ask "What must I do?" but to ask "What are the rest doing?"

The nursing profession has not escaped this loss of individual responsibility. The idea of personal service and sacrifice, of duty freely accepted and rigorously sustained, has lost some of its strength among us. We must, at all costs, restore it.

Here our task lies-in the coming

year and in the years to follow, we must do what we can to restore the values of civilized society. We must accept each man (and woman) as a distinct personality and we must respect his uniqueness for he has a citadel which is sacred and is possessed of inviolable human rights. We must endeavor to restore responsibility to the individual, for without individual responsibility society lacks stability and integrity. We must win back, as best we can, these important values without which any civilization, however highly organized, however "progressive," is only a mockery.

RAE CHITTICK
President
Canadian Nurses' Association

Stop Press!

Epoch-Making News

HISTORY IS REPEATING ITSELF in the matter of relationships between the Canadian Red Cross Society and Canadian nursing; it is a story of happy co-operation between two groups who have common interests.

The beginning was made at the end of the first World War when the Canadian Red Cross, through its provincial divisions, enabled the nursing profession to make progress in the field of nursing education by the establishment of formal post-graduate courses in a number of our universities. It was financial support from the Red Cross over a trial period that made this possible. Now, at the end of this second war, the Red Cross is putting its faith in us again, and again it is promising support for developments in nursing education.

The Canadian Nurses' Association has been able to name the project upon which it wishes to concentrate, and

this time the intention is to strengthen the basic professional course by establishing a demonstration school which is to have financial independence, though still a "hospital school" in general character. As the student is to be freed from economic dependence upon the hospital coffers, all of her time can be used to her own practical advantage; thus it is hoped that the length of the basic course can be made appreciably shorter. The graduate of this demonstration school is to have full registration status, and thus to be made eligible for postgraduate courses designed for graduates of approved nursing schools. The Red Cross has promised financial support for a four-year demonstration period. This evidence of faith in our professional group provides a challenge which the C.N.A. hopes to meet as worthily as did our sisters of 1920.

The Practical Importance of the Rh Factor

R. L. DENTON, M.D.

THE HISTORY of the development of knowledge concerning blood groups and transfusions provides one of the interesting stories of medical research and an example of the determination of a single individual, Professor Karl Landsteiner. Previous to 1900, blood transfusion was an extremely risky procedure, in spite of many attempts over a period of more than a hundred years prior to this date. At this time, Dr. Landsteiner demonstrated that the blood of human beings could be divided into four main groups, which he called A, B, AB and O, and that transfusion of blood of the same group to a recipient was a safe procedure, whereas the transfusion of a different group was usually fatal. His efforts, however, did not cease at this point and a few years later he demonstrated two additional characteristics of human blood, which he called M and N, providing thereby three new types, M, N and MN. Still later, he was instrumental in discovering an additional type, which he called P. At this time Dr. Landsteiner was so certain that still undiscovered group characteristics existed that he forecast that it might be possible at some time to recognize individuals by their blood groups and types with as much accuracy as is possible by fingerprints.

In spite of advancing years, he continued his search for blood characteristics and, in conjunction with Dr. Alexander Wiener in 1940, he demonstrated another blood type, which he called the Rh type. Since then it has been found that this Rh type is present in approximately 87 per cent of white people, these individuals being called Rh positive. The 13 per cent of white people who do not have this characteristic are called Rh negative. However, in other races, the proportion is somewhat different. The Negro race is 90 per cent positive and 10 per cent

negative; Oriental races are almost without exception Rh positive.

THE NATURE OF THE RH TYPE

The Rh factor, as it is called, is attached to the red blood cells and is undoubtedly present in the individual tissue cells as well. There is some evidence to show that it is present in soluble form in plasma and the various secretions of the Rh positive individual.

The Rh characteristic is acquired by an individual by direct inheritance from his parents. We now know that every individual may have two Rh genes, one of which is transmitted to his or her child. Each of us receives one Rh characteristic from our mother and one Rh characteristic from our father. There are, therefore, three possible combinations of individuals:

- 1. Those who are completely Rh positive (homozygous).
- 2. Those who are a combination of one Rh positive gene and one Rh negative gene (heterozygous).
 - 3. Those who are completely Rh negative.

The practical importance of the Rh factor lies in its ability to stimulate the formation of Anti-Rh antibodies when introduced into the body of a person who does not have this Rh characteristic. This antibody does not occur naturally in any Rh negative person but, following the introduction of Rh positive material, the antibody is formed and that Rh negative individual is said to be "sensitized." There are three possible routes by which the Rh factor may enter an Rh negative person and thereby set up a state of sensitization. These are:

1. By pregnancy: An Rh negative mother may have, in utero, an Rh positive fetus, whose Rh type was inherited from the father who is Rh positive. Small amounts of blood or

JANUARY, 1947

tissue cells from the fetus enter the maternal circulation through the placenta during pregnancy, or as a result of torn blood vessels at labor. Anti-Rh antibodies are then stimulated in the mother and, as a result, she is "sensitized." As a rule, the fetus which causes the sensitization is not affected by the Anti-Rh antibodies of the mother, probably because sensitization does not take place until very late in that pregnancy or may not even occur until several days after the time of delivery. Subsequent pregnancies, however, in which the fetus is Rh positive, are subject to an ever-rising degree of sensitization in this mother. In the later stages of pregnancy, the Anti-Rh antibodies of the mother begin to return through the placenta back to the very infant which stimulated their production. The antibody, being specific for the Rh positive blood and tissue cells of the baby, causes damage to these tissues and the result is a severe degree of anemia, due to destruction of red blood cells and, in addition, damage to liver, spleen, and other organs. This condition is called erythroblastosis, or hemolytic disease of the newborn. The severity of damage to the infant is usually mild in the first child to be affected but, with subsequent Rh positive pregnancies, the damage becomes increasingly more severe and finally reaches the stage of causing death of the infant shortly after birth, or miscarriage late in pregnancy. Fortunately, however, sensitization of the Rh negative mother by an Rh positive fetus does not occur in every case where such incompatibility exists. For some reason or other, only 1 in 20 such mothers becomes sensitized and has an affected infant. The remaining 19 do not become sensitized and may have perfectly normal children, even though they be Rh positive.

2. By transfusion: In transfusion therapy, a large number of blood cells are introduced into a recipient. If that recipient is Rh negative there is an 87-13 chance that he or she will receive Rh positive blood, unless special tests are done beforehand to

ensure that the recipient receives his or her own Rh type of blood. If such precautions are not taken and Rh positive blood is transfused into an Rh negative individual, a state of sensitization to the Rh factor, with the production of Anti-Rh antibodies. will occur in more than 40 per cent of such individuals. The transfusion responsible for initiation of sensitization gives no demonstrable reaction, except for the production of Anti-Rh antibodies which can be recognized by special tests. Subsequent Rh positive transfusions, however, may introduce another large amount of Rh positive blood into an environment where specific Anti-Rh antibodies are lying in wait; the antibodies attack and destroy the blood cells being infused and the result is severe, very often fatal, hemolytic transfusion reaction. It is possible, of course, for the combination of pregnancy and transfusion modes of sensitization to occur in rapid sequence, as, for example, an Rh negative mother, who has been sensitized by pregnancy, may have a postpartum transfusion and die as a result of destruction of Rh positive transfused blood by the antibodies she developed as a result of pregnancy. Similarly, an Rh negative mother who has been sensitized, even in early childhood by a transfusion of Rh positive blood, stands a good chance of losing all of her children, even the first, since her chances of marrying an Rh positive man and having Rh positive pregnancies are 7 to 1.

3. The third means by which Rh sensitization can occur is, fortunately, infrequent, that is, via the intramuscular injection of Rh positive blood into an Rh negative person. This procedure, once the common therapeutic technique for the treatment of hemorrhagic disease of the newborn, is, fortunately, almost nonexistent since the advent of vitamin There are cases on record, however, in which female infants have been sensitized in this way and remain sensitized until their child-bearing years, at which time they lost their first and subsequent Rh positive

offspring.

It is of the utmost importance that we remain aware of the catastrophic effects of Rh sensitization and do everything in our power to avoid their recurrence. Methods of prevention are restricted at the present time to blood transfusion therapy. It is essential that every recipient of transfusion, but especially girls and women before or during child-bearing years, should be typed for the Rh characteristic and when Rh negative that they receive only Rh negative blood. This, of course, applies to all recipients of transfusion since one can never be certain today that further transfusions will not be necessary at some later date, perhaps with the patient in an unconscious state where he or she is not able to inform the attending doctor that Rh sensitization may have occurred in the past. There is, unfortunately, no prevention for Rh sensitization due to pregnancy. It has been proposed by one authority that marriage of an Rh negative woman to

an Rh positive man be discouraged. but one may easily argue that there are other incompatibilities in the state of marriage of greater potential danger than a 1 in 20 risk of Rh sensitization. It is essential, however, to type and recognize Rh negative pregnant women, in order that one may be prepared for the birth of an erythroblastotic infant, and have all the necessary therapeutic equipment available in order to give the infant the best chance of survival. The early delivery of an Rh negative woman. known to have a rising Rh antibody level, has succeeded in many cases in saving an anemic baby, where previous full-term children had not survived.

The thing of greatest importance, to repeat, is to avoid sensitizing Rh negative individuals to the Rh factor, by taking every possible precaution to ensure that donors and recipients of transfusion have the benefit of recognition of their Rh type.

The Superintendent Does the Buying

HILDA M. BARTSCH

IN MOST SMALL HOSPITALS the nurse superintendent is responsible for the buying of supplies in addition to her numerous other duties. variety of articles needed for departments from the operating-room to the boiler-room is legion and can be considered under the following headings: medical and surgical supplies, drugs, anesthetics housekeeping equipment, linen, stationery, maintenance supplies, and provisions. No attempt to discuss provisions is going to be made in this article. To nurses, who become hospital superintendents, buying in large quantities is a new experience and presents a problem.

If the problem is to be solved certain tools are needed. These include:

- 1. A system of listing the amounts of supplies purchased so that quantities and prices can be seen at a glance. There are a number of types of index systems and perpetual inventory forms which may be obtained from the stationery supply houses. However, the simplest method is to use ordinary 5" x 3" filing cards, arranged alphabetically.
- 2. A library of catalogues of surgical instruments, equipment of all kinds, drugs, furnishings, cleaning supplies, and of the various other articles, is needed.
 - 3. A list of reputable dealers.
- A letter-size filing drawer for advertising matter, which seems to be worth keeping, or which may be needed for future reference.
- 5. A file for prices and quotations, which will show the name of the firm, price, and

quantity to which price applies and the date. Here again the 5" x 3" filing card is convenient.

6. Order forms printed with the name of the hospital, space for a purchase order number and shipping instructions, as well as space for the name of the firm to which the order is being sent and their address. The original is sent to this firm and a copy of the order retained and filed. All goods purchased should be covered by official hospital orders and if ordered by telephone a confirmation should be sent. It is good policy to have it understood that goods will not be accepted unless so ordered. The order forms should be numbered and filed according to number.

The amount of stock which should be carried is influenced by several factors, such as the amount needed to cover somewhat more than the average needs during time it takes to procure new stock. This, in turn, will depend on the rate of consumption, distance from supply houses, and speed of freight or express deliveries. In the case of freight deliveries, there have been times during the last few years when it has taken up to six weeks to receive material from a distance which is less than a twentyfour hour trip by passenger train. If there is more than one railway line. one may be more direct than the other. If so, it is wise to designate the route by which goods are to be shipped when placing orders. In larger centres. where supply houses are located, daily deliveries can usually be obtained, but this does not apply to small hospitals at a distance from such centres.

The amount of money available may govern quantities of goods which can be bought at one time. Theoretically, a budget should be made up and the amount to be spent on the various types of supplies estimated. Judging from discussions and articles on the necessity of uniform methods of accounting, it is doubtful if many hospitals have the information needed for this purpose in a readily available form. If the hospital has an overdraft or has to pay interest on bonds, it is not wise to buy large quantities of goods to obtain a better price, when

this saving will be wiped out by interest charges.

Prices on all materials desired should be obtained from competitive firms. During the past few years the various controls have stabilized prices, so that prices on equal quantities of the same quality goods showed little variation. When these controls are removed, it will become necessary to check carefully to see that the best possible prices are obtained. Already one can see signs of dealers attempting to book orders for delivery considerably into the future. The following experience will illustrate this point: The representative of a soap company called on the long distance telephone and asked if we would place an order with him for delivery some months hence. As it happened the name of both the agent and his firm were unknown to me and I said we did not place verbal orders. The price offered was very slightly below current prices from the well-known firms, but this was laundry soap which he was selling, and a change in the type of soap would upset our washing formula and, therefore, would not be worth the slight saving. This story also shows how many things have to be taken into consideration when buying hospital supplies.

On certain supplies, such as gauze, contracts may be made and deliveries taken over an extended period. In this way it is often possible to secure a better price, than on the amount which would have to be delivered in one month.

At the time of writing, the lines which are still in short supply seem to be paper, textiles, dishes, and soaps. Quinine, as everyone knows, has been off the market since early in the war. Surgical instruments of good craftsmanship had not been obtainable since early in the war years, until fairly recently when some instruments of European manufacture again were available for Canadian hospitals. This will give hospitals the opportunity to increase their stocks of instruments or to make much needed replacements.

The question of buying from one dealer, or of spreading purchases, is

one on which opinions vary. If there are competitive dealers who give the hospitals the same service it is a good idea to divide the orders. However, in some lines the question of quantity would enter the picture, and orders should not be divided between two firms if that is going to cost the hospital more for the goods. Some hospitals buy from one firm one month and from another the following month. If merchandise procured from a supplier is durable and gives satisfaction it may be wise to continue buying from that firm. The more that the purchases are spread among different firms, the more accounts there will be to increase the work of bookkeeping.

Whether or not to see salesmen will depend on a number of factors. Sometimes it is worthwhile, when information obtained will save considerable correspondence. While it is a help to try to have fixed hours for salesmen to call, this is not always possible outside of the larger centres, as train and bus schedules may make it impossible for the salesmen to call at the time fixed. If the hospital has no use for the goods a particular company is selling, then it would seem a waste of time to see their representative a second time. They should not be permitted to visit wards and departments.

There is a mass of technical information about all of the types of supplies needed in a hospital and some knowledge must be acquired. However, to learn all about such a variety of articles would take the superintendent more than twenty-four hours a day; so if she will use commonsense in regard to most of them and apply the knowledge learned in the practice of nursing regarding many articles in everyday use, she will find she is able to buy wisely. Standardization

of equipment will help to cut down the variety of articles to be bought.

Articles may be found in the various hospital magazines covering various aspects of buying. An article in the Modern Hospital for January, 1946, entitled "Purchasing Remains Impersonal" which covers very fully the question of gifts, donations, and free samples, is well worth reading. The Canadian Hospital for February, 1946. contains an up-to-date Buyers' Directory, which lists most of the Canadian dealers in hospital supplies. "The Purchasing File," formerly "The Hospital Year Book," issued by the Modern Hospital Publishing Company, contains a much more detailed list of hospital suppliers, but these are practically all American firms. Buying American products means that the cost of the goods will be increased by the amount of American exchange that has to be paid. The question of duty should also be considered, when the final cost of American supplies is computed.

BIBLIOGRAPH"

- Fisher, Pearl R. Plan Today for Tomorrow's Purchases. Modern Hospital, May 1944.
- 2. Jones, W. J. Purchasing—An Essential Part of Hospital Economics. *The Canadian Hospital*, May 1944.
- 3. Kirby, L. F. C. Hospital Purchasing. The Canadian Hospital, July 1944.
- 4. Lacy, Walter N. The Purchasing Agent Selects a Salesman. *Modern Hospital*, July 1945.
- 5. Meyer, Paul. Purchase and Issuance. Modern Hospital, Dec. 1945.
- 6. The Buyers' Directory. The Canadian Hospital, Feb. 1946.
- 7. The Purchasing File. Modern Hospital Publishing Company, 1945-46.
- 8. Small Hospital Forum. Purchasing Remains Impersonal. *Modern Hospital*, Jan. 1946.

Preview

Last month we featured Tuberculosis as our main theme. Next month we propose to give special prominence to various aspects of psychiatry and psychiatric nursing. Dr. Ewen Cameron, Mildred Nelson, and Ella G. Smith will be our contributors.

The Nurse and Cancer Control

ALICE K. SMITH

THE NURSE'S OPPORTUNITY for service has never been greater in any field of endeavor than it is today in the field of cancer control. The challenge which this problem presents has never been surpassed. Soon after the student enters the school of nursing, she is confronted with this challenge and from then on the possibilities for service multiply.

Our responsibility really begins before we enter the school of nursing, the responsibility which is that of every adult to know the essential facts concerning the disease. Through expansion of the work just being commenced in high schools, it will not be long before nurses entering schools of nursing will have a much truer conception of the nature of cancer itself and the cancer problem than many of us had when we graduated. Up to the moment, however, not every student nurse has received previous instruction in this subject. The result is that her attitude may be distorted by erroneous beliefs still held by many people; she may be unduly pessimistic about the whole problem. Extreme pessimism is commonly the attitude of the uninformed, and this is not surprising since a death from cancer in any community becomes common knowledge, while very few people hear about those friends and acquaintances who have been treated successfully.

Only through a thorough understanding of today's knowledge concerning the disease can a nurse make her most effective contribution. Her attitude toward the whole problem must be carefully molded by factual information early in her nursing experience. This is important because a high percentage of our hospitalized cancer patients receive their care almost exclusively from student nurses. In order to be of maximum help to the patient she must be equipped with more than a knowledge of nursing procedures.

On the surface, it would appear that the nursing care required by a cancer patient is simply good general nursing care, plus alertness for changes in the condition of the patient, and ability to carry out with skill orders as prescribed by the physician in charge. Actually. the responsibility of the nurse caring for a cancer patient is much greater Due to the fact that than this. cancer can be, and is, if allowed to advance before recognized, an alarming disease both to the patient and to his family, the part which the nurse is privileged to play extends far beyond the skill with which she is able to carry out procedures. The care of the cancer patient provides one of the greatest opportunities to practise nursing as an art. psychological aspect, the ability to lend fortitude which will relieve the mental suffering of the patient, is so important. To realize the truth of this one has but to imagine one's self on the place of the patient or his family. Even with the knowledge that the cancer patient definitely can be treated successfully if the disease is found early enough to be completely eradicated, the diagnosis of cancer of most sites remains a very sobering experience.

It is true, patients are not always told they have cancer. While some doctors make a practice of never telling the patient that he has cancer, others almost always tell the patient. Most doctors consider each patient individually in this regard. telling those they judge should know and withholding the knowledge from others. Some member of the family is almost always informed. generally acknowledged that the best co-operation is received from patients who are informed concerning the true nature of their condition. Whether or not the patient knows that he has cancer soon after a diagnosis is made, nine out of ten who are treated in

the later stages of the disease will know eventually. When, through her close association with the patient, the nurse learns that the patient does know the true nature of his condition despite the fact that he has not been told by his doctor, she should see that the doctor is informed of this fact. Confidence in his doctor. and all those in whose hands he finds himself, is essential to the well-being of the patient. Confidence is not strengthened by deceit, even when the cause may appear to have been in the best interests of the person being deceived. In regard to those who are treated early and successfully it would seem that most of them, at least, should be told the truth at some time. Such knowledge would do much to dispel the deeply rooted traditional belief that cancer is always a hopeless disease.

A sincere and unlagging interest in the welfare of the patient should be shown at all times. Whether or not he has been treated early, kindly optimism and cheerfulness used with the best possible judgment should prevail. This will assist the patient who is going to get well in adopting the correct attitude, and certainly will do much to alleviate the mental distress of the terminal patient. This, in many cases, is his greatest need. The words of Dr. Hyman Goldstein, in his article "Nursing the Aged," states most aptly:

Your very thoughts will unconsciously mold your actions. As a result your patient will sense your thoughts instinctively, and this may work for or against you. Your gentle touch as you braid the hair of the kindly diabetic in Room 36 will tell her volumes. But awkward hesitant movements will reveal the conflict within you and will tell your cancerous patient that you dislike sponging him. To your patient this is but further evidence to bolster his already well-formed belief that he is not wanted.

Regardless of whether or not the patient knows the true nature of his condition, the principles involved in the nursing care remain the same.

While experience in this field begins in the hospital with the actual bedside care of the cancer patient, there are many avenues within the

whole plan for cancer control, through which the nurse can render valuable service. In order to have a clear picture of how and where the nurse fits into an overall cancer program, let us review briefly the problem which the disease presents.

Cancer is, of course, a fundamental disease of the cellular structure of the body. There are as many different characteristics of the disease as there are different cell characteristics, and there are as many cell characteristics as there are organs. One has to be prepared to have different ideas about the disease in different parts of the body, ideas as to its incidence and of the chance of recovery of the patient, as to the methods of treatment, and so on.

Today the only hope of treating a cancer patient successfully lies in the complete eradication of all cancerous cells. This is possible when the disease is found early because it is localized. Once metastasis has begun, however, the chances of cure drop rapidly because the cells frequently migrate to obscure areas where they escape removal by surgery or destruction by radiation.

The fact that the disease rarely causes pain or discomfort at its onset, and that the first symptoms, when they do appear, are exceedingly mild deviations from the normal, is largely responsible for the fact that cancer often reaches a moderately or even far advanced stage before it is recognized. If the disease were painful at its onset the problem of early diagnosis would be very greatly reduced.

The accompanying table deals with the incidence of cancer according to site. It also gives the chance of cure that may be expected as of today, and the chance of cure that may be anticipated in what we hope will be the not too far distant future as the plans for cancer control are extended throughout this Dominion.

All in all, it will be seen that there is a very real expectation of hope for every second cancer patient, and the picture looks very grim indeed for the other 50 per cent.

CANCER CASES			Actual Recovery Percentage According		Estimated Recovery Percentage Under Ideal Conditions According	
Site	Number of cases	Percentage of total cancer cases	to site	to total cancer cases	to site	to total cancer cases
Buccal	71	5.6	76	4.2	95	5.3
Digestive	500	40 3	17	6.8	25	10.1
Respiratory	81	6.4	15	1.0	20	1.3
Uterus, all sites aver	80	6.3	40	2.5	90	5.65
Other female genital	38	3.0	26	1.0	50	1 5
Breast	158	12.5	45	5.5	75	9 4
Male genital	66	5.2	47	2.4	75	3.9
Urinary	83	6.6	37	2.4	50	3 3
Skin	49	3.9	71	2.8	99	3 9
Other Sites	125	10.0	32	3.2	. 50	5.0
Total	1260			31.8		49.3
			Present average recovery rate		Estimated best recovery rate	

Considering the grim side of the picture first, we realize this very unhappy situation is due to the fact that the fundamental scientific knowledge about the cancer processes is nothing like the knowledge that we have about many other diseases, particularly the infectious diseases. At present, the machinery that goes wrong to upset the normal cells of the body organs and cause them to be malignant is not understood, nor at the moment is there any clear picture as to how one should go about causing the cancer cells to return to normal. Until such knowledge is available, it is obvious that no method aimed at curing the cancer itself can exist. There is, then. a vital need for extensive scientific investigation of the cancer problem. This, of course, will only be forthcoming when the public is so aware of the necessity of carrying out this class of work that it will be prepared either to support it directly or back up governments in setting aside money for this purpose. The nurse has many

opportunities to interpret this need.

To turn attention now to the brighter side of the picture, to the 50 per cent that can be saved, it will be appreciated at the outset that the methods of treatment used are not aimed at curing the cancer itself but rather at eradicating it from the body so that the patient may be free from the disease.

The main emphasis in cancer therapy is upon surgery. X-ray and radium also have a place in the treatment of cancer patients but this place largely subsidiary to surgery. Radium and x-ray tend to destroy every living thing with which they come in contact and their destructive action increases with the activity of the living unit which they strike. Their value in the treatment of cancer patients lies in the fact that cancer cells are more actively growing than their healthy neighbors, and so radiations may be successful in destroying the malignant cells without inflicting major destruction upon adjacent healthy tissue.

In a cross-section of 821 cases taken from one clinic's records, 60 per cent of all the cases were treated by surgical procedures alone. Another 23 per cent had surgery as the major procedure, and this was supplemented with radium or x-ray, so that well over 80 per cent are to be considered primarily surgical cases. X-ray, radium, and x-ray and radium jointly were only used in 8 per cent of all the cases with the hope of achieving cure, and they were used in the other 9 per cent merely as palliative measures.

The fact that surgery and nursing care go hand in hand is another reason that the role of the nurse figures large in the care of the cancer patient.

Outside of the hospital walls the nurse's first responsibility is to prevent as many people as possible from becoming terminal cancer patients through promoting early detection of the disease by every known means. By being alert for symptoms which may possibly mean cancer in those whom she contacts, and by opening the way to early and adequate investigation of such symptoms she can do much, but her greatest scope lies in the field of education. While opportunities in this field come to every nurse, the greater number come to the public health nurse.

All public health nurses who have worked in rural areas will be thoroughly familiar with the fact that opening gates was one of the first things she had to become accustomed to in getting around her district. Public health nursing is a continuous series of opening gates, gates to more healthful living, letting down the bars of fear and misunderstanding which cause so much preventable illness and so many premature deaths. Every nurse should be a teacher, but the public health nurse must be a teacher. Only through effective teaching can she hope to change attitudes which are constantly in the way of achieving maximum conditions of positive health. This is true in relation to all of her work, but it is particularly true in regard to the field of cancer, the main reasons being: the insidious onset of the disease, firmly rooted false beliefs, and, most important of all, the fact that today cancer cannot be treated successfully unless it is treated early. It is estimated very conservatively that at least 25 per cent of present cancer deaths could be prevented if everyone knew enough about the disease to realize when it is necessary to seek medical aid.

People must be taught the facts if they are to deal with this problem to their best personal advantage. If they are to believe that it is possible to be treated successfully for cancer, and if they are to understand why treatment must take place early. they must know something about the nature of the disease. Dangerous false beliefs must be replaced by factual knowledge. There is little use telling people that many cancers can be cured, that there are many needless deaths from this disease, unless we make them understand why this statement is true and show them the important part which they have to play. They must be made to realize that the first responsibility lies with the individual, that unless the individual consults his doctor before the disease becomes advanced, with present day knowledge, his doctor is powerless to help him. Next to the family doctor it would seem that no one is in a better position to impart the necessary information to the people than the public health nurse. Because of the nature of her training and experience she is uniquely fitted to inspire confidence in her opinion and is also equipped to discuss the highly personal matters often involved.

There are two chief methods of teaching open to the public health nurse: the first is individual or person to person; the second is group teaching. Both methods have their merits but the first, or individual, is usually the more effective. The nurse has many opportunities to carry out this kind of teaching as she goes about her work. For example, when she makes a birth-registration visit she has an opportunity to discuss the importance of the postpartum examination and prompt repair of any birth

injury. The child health clinic provides a similar opportunity to discuss this point. Women need to be taught that excessive or unexplained bleeding always requires investigation. The need for alertness for a lump or other suspicious changes in the breasts must be stressed. There will be ample opportunities to discuss the value of adequate mouth hygiene as it relates to the prevention of cancerous conditions of the buccal cavity. The hazards of taking home remedies constantly to allay "indigestion" instead of having a thorough investigation made can be explained. The possible meaning of changes in the appearance of a mole or wart should be pointed out at every opportunity. It isn't necessary to go into further detail the nurse who is truly "cancer conscious" will find opportunities crowding in, one upon another, to teach the important facts about the disease.

The manner in which the nurse imparts information is important. She should be frank, adhering strictly to factual and well-authorized information but should always try to stress the reasons for optimism. Certainly, pessimism has been overworked in this field and actually is responsible for many deaths today. The excessively long average period of delay between onset of symptoms and the patient's first consultation with his doctor is frequently due to this pessimism. It should be stressed that the mild symptoms which may mean cancer, more often than not do not mean cancer. But it should be made very plain that the only way to find out is by having a thorough examination made.

Group teaching falls into two main classes: firstly, the small groups made up of members of a single organization, for example, a Mothers' Club, a Women's Institute, and numerous similar groups; and, secondly, the large public meeting. A great deal can be accomplished with the small groups because the members are usually acquainted and so discussion is spontaneous.

The chief reason for the large general public meeting is to cover a large number of people at one time. It is desirable to have a local doctor assist with large meetings if at all possible. Usually they are arranged under the sponsorship of some local committee or organization. The medical speaker should be chosen by the members of the sponsoring group.

Good films are exceedingly helpful

at all meetings.

Only through an understanding of what is being done, and what the plans, hopes, and needs for the future are, will the confidence and support of the public be maintained, and the confidence and support of the public must be maintained if progress is to be made. It is part of the nurse's responsibility to see that the needs are interpreted to the people.

Another avenue through which the public health nurse can influence progress in cancer education is the high school. It is now agreed by practically all authorities, in the field of education as well as health, that the high school students offer one of the most promising fields for cancer education. Books on this subject suitable for high schools are now

being introduced.

We cannot conclude a discussion concerning education for the early detection of cancer without mentioning the value of the regular thorough health examination. We are fully cognizant of the difficulties which this matter projects in the minds of a great many of our people, both lay and professional. Despite this, however, the fact remains that, if we are to make the best possible use of the knowledge which is available today concerning the control of this disease, we must utilize this tool. As long as it is necessary to find cancer early to treat the patient successfully does it not seem that the health examination should be considered a practical procedure in the field of cancer control?

The other services which the nurse is able to render in the field of cancer do not differ greatly from her work in relation to most other conditions. Persons who have been treated for cancer require close observation for a long time. It is frequently the public health nurse's job to convince the patient of the necessity for returning to his doctor for follow-up examinations and helping him to circumvent obstacles such as financial problems which prevent him from co-operating fully. Through helping to keep the patients under observation, the nurse is also assisting with the collection of valuable statistical data.

Occasionally, through lack of understanding, persons receiving deep x-ray therapy decide to discontinue the treatment before the course has been completed. Usually, these persons have had some reaction to the x-radiation and do not understand the value of enduring some temporary discomfort in order to safeguard themselves, insofar as is possible, against much more severe suffering. The pub-

lic health nurse can frequently seek out these people and help them to

appreciate the facts.

Finally, there is the service to the cancer patient in the home. Here the private duty nurse is able to make a great contribution, perhaps even greater than in the hospital, because she has a better opportunity to sense the difficulties and problems of both the patient and his family and through this better understanding is often able to be of greater help. public health nurse, too, has many opportunities to be of assistance to the cancer patient in the home by carrying out bedside care on a visiting basis, by teaching some member of the family or household the correct care of the patient, and by assisting with the solution of any problems which obviously need her help.

An Instructors' Group Holds a Psychiatric Institute

Last year, the Instructors' Group of Alberta attended a two-day psychiatric institute at Ponoka Mental Hospital. The attendance was excellent as seventeen instructors from hospitals in the north and south of the province were present.

When programs of the proposed schedule of activities for the two days were given to us, we found we were going to see everything, hear everything, and experience everything that the hospital and staff could offer — and so it proved to be.

Under the leadership of Miss Mildred Nelson, instructor of nurses, and Miss Nessa Leckie, assistant instructor, we were conducted on a tour that took us to representative sections of the hospital. Here, in pleasant, cheerful surroundings, we saw many patients (the hospital has well over a thousand) sewing, reading, knitting, playing cards, or listening to the radio in the large comfortable sitting-room.

Many of the patients take a much more active interest in their surroundings, as a great number were seen everywhere busily sweeping, dusting, cleaning rooms, and working in the kitchens, laundry, sewing-room, bakery, and printshop.

Our visit to the occupational therapy studios was particularly interesting. In fact, our guides had some difficulty in getting us to leave. Here we saw patients making intricate and delicate wood-carvings furniture, weaving cloth, and cutting and stitching leather articles. I think we were all rather regretful when it was time to leave such a happy and cheerful assembly.

The visit to the treatment wards was especially educational. There we saw patients undergoing electric shock therapy, hydrotherapy, and malarial fever treatments. Conversations with some of the patients were interesting and enlightening. Many of them say they feel so much better following their electric shock treatments and that this newer treatment is much to be preferred to other types of shock treatments.

Subsequent tours gave us glimpses of the "stores," the dental office for the care of the patients, the admitting office, the medical library, the conference room, where patients are periodically interviewed and examined, the patients' library and canteen which are operated by the patients, under the supervision of the occupational therapist. Last but not least, we saw the beauty parlor

in full operation. The staff is unanimous in declaring that this beauty parlor is of prime importance in establishing and maintaining personal pride in appearance, and raising the morale of the female patients. We all know what a wave after a shampoo does for us!

The group also attended several very interesting and informative lectures. These were presented in such a way as to give us much needed information, and roused so much interest that many in the group declared that working in a mental hospital such as Ponoka would be a very pleasant experience. The institute drew to a close with an appetizing

and beautifully arranged buffet supper, which was enjoyed by all.

As the instructors of the group have long felt the need for a better understanding of psychiatric nursing and of psychiatric institutions, we feel that after having attended this two-day course we at least have a better appreciation of the value of such a training for all nurses. We are now looking forward to the day when the schools of nursing in Alberta will have affiliations with psychiatric hospitals, in order that the student nurses may have a more complete training in the profession of nursing.

Take it Off!!!

DOROTHEA LAKE

At the spring meeting of the Committee on Instruction, District 5, R.N.A.O., it was requested by the committee that cultures be taken of various types of watches and rings—jewellery worn on duty by nurses doing bedside care. Appealing to the nurse to remove the glamour from her uniform has not been effective, and it was thought that by having such experiments carried out, and by making the results known, nurses would become more conscious of good medical asepsis.

Preliminary experiments were conducted on the problem of cross infection by contaminated rings and watches in the wards of the Toronto General Hospital. Five student nurses were chosen from each of - the medical department, the surgical department, and the Burnside obstetrical department. Each of these students was instructed to wear a watch and a ring on duty the following day. After morning care was completed, cultures were taken of the watches and rings, care being taken not to touch the skin. Each nurse then washed her hands thoroughly, not scrubbing, and a second culture was taken. The cultures were delivered to the Banting Institute and planted immediately. The results showed that rings and watches carry similar bacteria to those present on the skin, and even when the hands were thoroughly washed only a few colonies of bacteria were destroyed.

Dr. Philip Greey requested that the experiments be repeated and that Dr. Alice

Gray accompany the nurses and do a direct planting of the culture to prevent contamination and to give a more accurate picture.

On an appointed day cultures were again taken from nurses working in the same departments as before. These nurses carried out routine duties on the ward until ten o'clock. At this time cultures were taken with moist swabs and planted directly on blood agar plates. After the nurses had washed their hands, a second culture was taken and planted as before. On examination it was found that Staphylococcus albus and Staph, aureus were present on every plate but one, while aerobic spore-bearing bacilli occurred on about half of the cultures. The bacterial flora on the jewellery of dressing nurses varied little from that on the rings and watches of nurses concerned only with bedside care.

Similar experiments to the above were carried out at Wellesley Hospital, Toronto, and at the Toronto Hospital for Consumptives, Weston, with essentially the same results.

The foregoing experiments should provide sufficient evidence for nurses to refrain from adding jewellery to an already attractive uniform.

Wear the glamour with your civvies!

—The Quarterly, published by the Alumnae Association of the Toronto General Hospital.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Use of the Volunteer Worker in a Public Health Nursing Service

KATHERINE BARR

DURING THE WAR YEARS, the City of Winnipeg Health Department, like most other community agencies throughout Canada, encountered the difficulties resulting from shortage of personnel, frequent changes of staff, heavy case loads, enlarged districts, not to mention the added duties which an expanding health program brought into being.

To meet community needs and to enable trained personnel to make better use of their special preparation, the assistance of the volunteer worker was sought on many occasions. Now that we are in the long talked of post-war period, now that we have had the time and opportunity to evaluate the contribution of the volunteer worker in the health program, we appreciate the fact that without such assistance, we would, no doubt, have fallen short in supplying the health services which the people in our local communities needed and expected.

While volunteers have from time to time ably assisted with mass toxoid surveys in schools, mass x-ray surveys of business firms, industries and high schools, and in various clerical duties, they have, perhaps, made their most outstanding contribution in our child health centres.

Weekly, in twelve child health

centres located in various areas of the city, volunteers engage in certain specified duties:

Weighing and measuring of infants and preschool children; recording weights and filing records; directing mothers to nurses or doctors, in turn, thus facilitating the smooth running of the clinic; helping nurses to set up the clinic; assisting the physician on immunization day; supervising and playing with children while mothers are attending classes in child care.

A public health nurse is responsible for interpreting the objectives of the services and for outlining and explaining the duties of the volunteers at that particular centre. As far as possible we have tried to adopt a system of rotation of duties so that each volunteer will have a variety of interests within the centre and in this way will not become attached to any one experience which she might tend to monopolize as her own particular field.

Volunteers come to our agency through the Central Volunteer Bureau. From time to time the public health nurse in charge of the child health centres is asked to send to the bureau a report of the work of the volunteer. Such things as regularity of attendance, promptness, efficiency in assigned tasks, special interests and abilities are noted. This is not done with a view to criticizing or chastising the volunteer, but

JANUARY, 1947 35

rather as a means of placing each volunteer in a job which she can do well and at the same time experience that degree of personal satisfaction which is, in the long run, the volunteer's only reward for her efforts.

Realizing that the satisfaction of work well done is the volunteer's only gain, our department has tried from time to time to show its appreciation in a tangible way. Shortly after the initiating of the volunteer workers into our program, the Health Committee of the City Council held an evening reception in their honor. However, more successful than a large gathering, we have found that an invitation to an office tea party, a few kindly words at the end of the day, a short letter of thanks when a

volunteer leaves the service, help to stimulate that feeling of worthwhileness in the tasks performed.

In evaluating the reaction of our volunteers to the work which they have done and are doing so faithfully at present, we have discovered that the whole experience is a twoway process. While volunteers have a service to offer, a contribution to make, they are not the kind of people who are able to appreciate passively what they see, hear and feel at a child health centre. They take their experiences home with them. are influential in bringing about in their communities a better understanding of the principles of public health. They have an opportunity to do a real job of citizen education.

Organizing a Well Baby Clinic

MAY G. DOUGLAS

CMITHERS, B.C., with a population of 951, is situated approximately midway between Prince Rupert and Prince George on the northern line of the Canadian National Railways. Built for the most part on muskeg, the town's sewage and drainage facilities present a marked problem to the householder. Improper drainage constantly endangers the water supply, which is at present each individual's responsibility in his own home. Water is procured by driving a sandpoint into the ground and attaching to it an electric pump or a hand pump.

With the above disadvantages one would presume that the average rate of sickness, per capita, due to the consumption of a dubious water supply, would be much higher than in a town built on a more suitable location. This, however, is not the case. There is no record of any serious epidemic in Smithers and, apart from bi-annual gastro-intestinal upsets, facetiously termed "Ditch Fever,"

the children are average, and sometimes better than average, in health.

The Smithers Chapter of the Registered Nurses' Association of British Columbia, formed in 1944, is comprised of seventeen members, the majority of whom are wives and mothers. In October, 1944, due to the absence of a public health unit to serve Smithers and the large surrounding district, it was decided that our Chapter would take upon itself the onus of founding and operating a well baby clinic.

By correspondence, we received expert advice and willing co-operation from Miss Dorothy Tate, R.N., director of public health nursing with the B.C. Provincial Board of Health. Plans went forward to raise our own funds and acquire suitable equipment to enable us to open our clinic in the first month of 1945. Our first few clinics were held in the Municipal Hall on the first Saturday in the month and one, in the office of Dr. L. M. Greene, on the third

Wednesday in the same month from 2.30 to 4.00 p.m. These days and locations were so designated to accommodate farmers from the outlying districts and to utilize the only space available to us at the time. The confusion resulting from two locations and two dates has since been eliminated by holding the clinic once monthly in the doctor's office. We find the farmers' wives sufficiently interested to make an effort to be in town for "Clinic Day."

Service in the clinic is supplied by the Chapter members who attend in groups of three, three times in succession, alternating so that at least one of the nurses present has attended the previous clinic. We find this system excellent, inasmuch as any problems brought up at a clinic may be dealt with, if necessary, by a person acquainted with the problem, at the following clinic. In this way, too, the mothers acquire confidence in not having to explain to, and ask advice of, a new nurse at each clinic.

The equipment required to operate is: one pair of baby scales; one large table for stripping the babies; an adequate supply of paper tray-covers to be placed atop oilcloth pads on which to examine babies; one filing box with individual cards for each child's clinical record; three white laboratory coats for nurses in attendance; a generous supply of literature procured from the provincial health department.

The chief service given the public through our clinic is immunization. Our average attendance is twelve babies, but we have had as many as thirty-five and as few as seven in attendance.

Our advice to the mothers is kept wholly within the realm of professional ethics and, although we have no doctor in attendance, we refer the mother, when necessary, to the local practitioner during his office hours. We presented our clinic to the public through our advertisement in the local newspaper and fostered attendance by personal calls and word of mouth. The new mothers in hospital are approached by the nurse on duty, and given a cordial invitation to bring the baby to clinic. We have discussed. and plan to execute a system, whereby each mother in hospital is presented with a suitable personal card from our clinic inviting her infant to attend.

We feel our clinic is a success. It fills a great need in our community and we meet with co-operation and gratitude throughout Smithers and its surrounding rural districts. Only the excellent work of each one of our members enables us to carry on our project, for we receive no financial assistance from any group or organization. None of our members has received special training in public health work, but each has had to learn, through applying herself, and, of course, through trial and error, to adapt herself to the public's needs.

Health Week-1947

The Health Week program of February, 1946, promoted by the Health League of Canada, was remarkably successful, owing to the fine co-operation of the nine provincial Departments of Education and of Health, the schools, churches, Home and School Associations, women's institutes, service clubs and other groups, press, radio, and film. The Health League of Canada is planning a more comprehensive Health Week campaign for February 2-8, 1947, with National Social Hygiene Day set for February 5. It is hoped

that all organizations interested in any way in the improvement of personal and public health will join in this movement.

Health is so fundamental for individuals and communities that it is good citizenship to do anything to promote better health. A Canada with 'optimum' health would lead the world in this great national asset. The Health League of Canada earnestly requests your co-operation in making known and supporting this Health Week Campaign. Help with your community's program.

A Vital Memorial

What would our world be like without books? Can you imagine yourself stripped of every piece of reading material? You would very shortly feel lost. How could you keep up with everyday events, with the serious things of life as well as the frivolous without books and magazines? Can you visualize yourself teaching student nurses without textbooks or nursing journals?

That is briefly the plight in which thousands of our colleagues have been finding themselves for the past few years. The libraries in the countries most grievously hit by the war, no matter what libraries they were, have been demolished to a great extent. There are schools of nursing in all of these countries — many of them have no textbooks at all! In some instances, they were all lost through the saturation bombings that took no account of any possessions. Others were destroyed by the enemy who occupied the areas. There is practically nothing the nurses can use.

Nurses in many lands had not written textbooks as they do in the countries with which we are familiar. Even before the war, it was necessary to provide them from outside sources. Now there is little paper available in Europe or in China for the printing of textbooks. The need, therefore, is enormous.

As a living, vital memorial to our nursing sisters of World War II, the Canadian Nurses' Association at its last biennial meeting endorsed the proposal that libraries be assembled and presented to the nurses in foreign lands. Books are expensive, both to purchase and to ship, so a large sum of money must be collected. It is proposed to stage a campaign all across Canada from January 1 to May 1 with the objective of raising \$32,000. You will be asked to contribute. Let your gratitude for our unscathed land be your guide in considering the size of your donation. A minimum of one dollar per nurse would enable us quickly and painlessly to reach our objective.

Obituaries

Frances Adelaide Acres, aged 20, died recently following a serious illness. Miss Acres was a student nurse at the Cornwall General Hospital, Ont.

Maria Fillmore, who was matron of the Provincial Mental Hospital, New Westminster, B.C., from 1897 until her retirement in 1939, died recently at the age of eightyseven years. A native of Cumberland County, N.S., Miss Fillmore received her training at the Worcester (Mass.) Mental Hospital. She began working in New Westminster in 1893.

Josephine Hamilton, who had the distinction of being the first graduate of the Hospital for Sick Children, Toronto, died on November 7, 1946, after being active in nursing for more than half a century. Though she had retired, Miss Hamilton returned to professional activity during World War II when in 1943, shortly after she had celebrated her seventy-third birthday, she worked on the nurses' registry.

Helen Joyce Davidson, who was a grad-

uate of St. John's Hospital and the University of Toronto School of Nursing, died on November 12, 1946. She had been in ill health for the past two years.

Miss Davidson served for four years as superintendent of the Toronto West End Creche and for eight years as visiting nurse for the Infants' Home. Later she joined the staff of the Toronto Department of Public Health.

Olive Young Rand, who was born in Canning, N.S., graduated from Royal Victoria Hospital, Montreal, and who spent most of her professional life in the United States, died on October 2, 1946. Miss Rand enlisted in the U.S. Army Nurse Corps in 1942. She served in France with the First General Hospital until after V-E Day. She is buried in Arlington Cemetery, Washington, D.C.

Margaret Zimmerman, who graduated from the Brantford General Hospital, Ont., in 1929, died suddenly in Noranda, P.Q., where she had been engaged in nursing since 1937.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Orientation of the Private Duty and General Duty Nurse

MILDRED KOCH

THE IDEA WAS CONCEIVED in the mind of a private duty nurse. It was a healthy idea, for it grew day by day as she nursed in a strange hospital. Surely something could be done to help her feel less strange and

helpless.

The idea took greater magnitude the morning that her patient, who had pneumonia, became very cyanosed and the need for oxygen and a respiratory stimulant was urgent. Where would she find the oxygen? Where were the stimulants kept? In factwhere was the head nurse? She was not in the chart room—Oh ves. there she was, taking a pre-operative to surgery and the tail of her uniform could be seen as she eased into the elevator. Yes, indeed, there was a need for some form of orientation, and a concise form, for the private duty nurse in this new hospital situation.

The idea of an orientation plan was conceived in the mind of a private duty nurse but the idea was born over a bottle of soft drink, when a general duty nurse, thinking along the same lines, added her miseries to those of the private duty nurse. She, too, had experienced the same confusion when she had recently taken a position on the staff of a hospital.

So, at the birth of the problem child, the general duty nurse and

private duty nurse turned their "baby" over to the care of the Hospital and School of Nursing Section of the Manitoba Association of Registered Nurses.

The problem was voiced, discussed, and solved at a meeting of the above section last spring. The presentation took the form of a dialogue forum which is here presented, followed by the solution which transpired as a result:

P.D. Miss R, you have recently taken a new position as general duty nurse at X Hospital. You probably have some ideas which will help us in discussing your adaptation to the new situation.

G.D. One of my biggest problems was becoming adjusted to the ward routine. I found that I could plan and arrange my work more effectively after I had gained working knowledge of the daily schedule of the ward. I feel that a definite plan made and presented to the new nurse when she comes to the ward would help overcome this difficulty.

P.D. What specifically do you mean by this "definite plan?"

G.D. I thought of either a typed copy of the ward routine to be posted in a conspicuous place or a ward manual which contained that plan. In your role as a private duty nurse, does this problem confront you?

JANUARY, 1947

P.D. Actually, the ward routine does not touch me as much as it would you but I think the private duty nurse sometimes forgets that her patient is, indeed, a part of the ward and that she is responsible to the supervisor for the care of her patient. My biggest problem was that of registering. Some hospitals seem quite lax about registering; others are very upset when you do not register the moment you report on a case. I can see where, in a large hospital, at least, this is very necessary. But the biggest obstacle was where to register. In some hospitals one registers in the T.S.O., in others in the business office. If only one knew where to register so that valuable time would not be wasted going from one office to the other! Another big help would be for a member of the T.S.O. to conduct the private duty nurse to the ward and introduce her to the supervisor. This is especially helpful when the private duty nurse has never been in the hospital before.

G.D. No, I don't think that the administrators can afford to take the

time for this.

P.D. Yet the administrators expect the private duty nurse to cooperate in ward routine. I think the proper introduction to the supervisors would promote this feeling of

co-operation.

G.D. I think that in order to get an idea of the plans the supervisor could make for the orientation of the new nurse to her ward, we should follow the new graduate from the time she enters the ward. The first thing that is necessary is a proper introduction to the personnel she will encounter and an explanation given of their duties on the ward. Then, a trip around the ward to familiarize her with its general plan would be advisable.

P.D. I found that the whereabouts of the linen cupboard, extra blankets, pillows and rubber goods, is of primary importance. The distribution of the supply of linen is controlled in some hospitals, while in others it is not. I found also that in some hospitals the linen came up from the laundry shortly after dinner and was dis-

tributed at this time to the various patients' bedsides. If one wasn't at the linen cupboard at the appointed time, an unhappy situation developed. My criticism here is not the method of distribution but the fact that the method is not known by a stranger.

G.D. The problem regarding the distribution of linen also applies to the general duty nurse, in that she should know where she may obtain supplies in cases of emergency. She should also be acquainted with the necessary requisitions for obtaining

such supplies.

P.D. The immediate problem of a private duty nurse is the location of the drugs. The narcotics are often needed for pre-operative medication as soon as she comes on in the morning. Where to find these drugs quickly and the necessary requisitions and bookkeeping involved are her immediate concern.

G.D. Is this as important a question in the introduction of a general duty nurse? Are her needs in this

respect as urgent?

P.D. The dressing facilities in various hospitals differ widely. In some hospitals there is a complete central dressing room; in others, some of the materials come from a central dressing room, the rest from the ward supply; and, again, some hospitals have the complete dressing facilities on the ward. When the doctor comes, the private duty nurse does not know where she may find her dressing equipment.

G.D. That brings up the point—should the general duty nurse be taught the standard nursing procedures of the hospital so that she may be competent in setting up the dressing trays in the manner followed by the hospital? If it is a training school she must know as she is a

potential teacher.

P.D. This brings up the problem of emergency equipment such as oxygen tanks, suction apparatus, etc. This information is as important to the private duty nurse as is the availability of the drugs.

G.D. To the general duty nurse, this can be a slower introduction and

may be taken in during the tour of the hospital where the laboratory is introduced and the location of the main depots are pointed out to her. This is very important in the orientation of the general duty nurse and should be included in the plan by the supervisor of the ward. The next point that seems to be important is that the general duty nurse must know the location and facilities of the diet kitchen and distribution of the diets.

P.D. The distribution of diets is quite varied. In some hospitals they have central diet kitchens; in others, part of the diet comes from the diet kitchen and the remainder from the ward. In most hospitals the private duty nurse prepares her tray prior to or immediately after the ward diet. However, in other hospitals, the complete tray is distributed by the diet kitchen. This causes considerable confusion to the strange private duty nurse unless she is thoroughly familiarized with the dietary routine.

G.D. In order to make the general duty nurse feel more at home, the supervisor should arrange for someone to accompany her to the first meal.

P.D. Often the private duty nurse does not eat in the hospital because no one introduces her to the hospital dining-room or the means by which she may obtain meals.

G.D. As a final point I would like to state that the general duty nurse should be made acquainted with the rules of procedure regarding calling doctors in the event of a serious turn in the patient's condition.

The topic was then left to the meeting for discussion. The problems

were solved as follows:

1. A well-planned orientation should be carried out for the general duty nurse taking a position in a new hospital. Such a plar. should extend over a fair period of time.

2. A concise chart with the geography of the hospital and the ward should be placed in a conspicuous place on each ward. Such a chart should point out clearly the location of emergency depots.

 It was felt that the Nurses' Directory could tell the private duty nurse where to register in the hospital, when the nurse is called on the case.

4. It was also felt that it was the duty of the private duty nurse to introduce herself to the ward personnel.

5. A card explaining the laundry rules, time of distribution, etc., could be tacked to the linen cupboard door or conveniently placed within the linen cupboard.

 A similar card in the ward kitchen would prepare the private duty nurse for the method of distribution of diets.

7. Someone on the ward, if not the supervisor, should be appointed to direct the general duty nurse and private duty nurse, if she so desires, to the dining-room.

Victorian Order of Nurses for Canada

The following are the recent appointments to, transfers, and resignations from the various branches of the Victorian Order of Nurses for Canada:

Appointments: Dorothy Geeson (University of Alberta Hospital and University of Alberta public health course) to Edmonton; Marjorie McIntosh, who received a Victorian Order scholarship and has completed the public health course at University of Toronto, as nurse-in-charge at Aurora; Elsie Waller (Hamilton General Hospital and University

of Toronto public health course) to Hamilton; Mrs. Libbie Rutherford (Montreal General Hospital and University of Toronto public health course), recently returned from overseas service with UNRRA, to Toronto.

Transfers: Dorothy King from Orillia to be nurse-in-charge at Brantford.

Resignations: Maude Tisdale from Toronto to be married; Mabel Russell from North Vancouver; Edith McLean from Calgary; Elizabeth Jenkins from Vancouver to be married; Margaret Janzen on leave of absence from Toronto.

M.L.I.C. Nursing Service

The following are recent changes of staff occurring in the Nursing Service of the Metropolitan Life Insurance Company:

Appointments: Apolline Coursol (Hotel Dieu Hospital, Montreal), Alphonsine Lemay (St. Michel Archange Hospital, Quebec City), Rose Theberge (Hôpital de l'Enfant Jésus, Quebec City), Antoinette Vachon (Hôpital de l'Enfant Jésus, Quebec City), to Montreal staff.

Transfers: Cecile Leclerc (Saint Jean de Dieu Hospital, Gamelin), Fernande Duclos (St. Sacrement Hospital, Quebec City), Antoinette Richard (St. François d'Assise Hospital, Quebec City), Pauline de Villers

(Notre Dame Hospital, Montreal, and University of Montreal public health course) from Montreal to Quebec City staff.

Resignations: Marguerite Ouellet (Hôpital de l'Enfant Jésus, Quebec City) and Jeanne Brais (Montreal General Hospital) from Montreal staff.

Gertrude Gouin (Notre Dame Hospital Montreal, and University of Montreal public health course) has resumed her duties on the Montreal staff after a leave of absence to join the R.C.A.M.C. in August, 1942. Adrienne St. Onge (Misericordia General Hospital, New York City) has resumed her duties on the Montreal staff.

Ontario Public Health Nursing Service

The following are the staff appointments to and resignations from the Ontario Public Health Nursing Service:

Appointments: Mrs. Noreen Heath (Royal Southern Hospital, Liverpool, Eng., and University of Pennsylvania public health course) to Bruce County health unit; Alice Klugman (Toronto Western Hospital and University of Western Ontario certificate course), formerly with Chatham Board of Health, to Guelph Board of Health; Mrs. Bertha Young (Ottawa Civic Hospital and University of Western Ontario certificate course) to Prescott Board of Health; Mrs. Isabel Gleason (Hamilton General Hospital and University of Toronto certificate course) to Haileybury Board of Health; Kathleen Bayley (Ottawa General Hospital and University of Ottawa certificate course) and Gladys Clark (Ottawa General Hospital and University of Ottawa certificate course) to Ottawa Board of Health.

Resignations: Mildred Haberer (Stratford General Hospital and University of Western Ontario certificate course) from Huron County school health service; Mrs. William (Walker) MacDougall (St. Joseph's Hospital, Toronto, and Ontario Department of Education summer course in school nursing) as supervisor of public health nursing, York Township Board of Health; Marguerile Court (St. Michael's Hospital, Toronto, and Ontario Department of Education summer course in

school nursing) from Sudbury separate school board; Elizabeth Ryan (St. Joseph's Hospital, London, and University of Western Ontario certificate course) from Lambton health unit; Elsie Wright (McKellar General Hospital, Fort William, and University of Toronto certificate course) from Port Arthur Board of Health.

Prize Winners

The decisions of judges selected to evaluate the entries in the *Journal's* 1946 article contest were received in time to forward the prizes to the contestants in time for their Christmas shopping forays. Each chose to write on the topic "Bedside Nursing — an Essential Service." Our congratulations go to the winners of these awards, who were:

First prize: Miss C. E. M. Rowles, Industrial Nurse, Dominion Glass Co. Ltd., Redcliff, Alberta.

Second prize: Miss Christine E. Charter, Vancouver, B.C.

The limited number of entries means one of two things — either the nurses of Canada are not interested in article contests or they found the topics unsuitable for their writing talents both in 1945 and 1946. Which was it? The Editorial Board and the editor would be interested in receiving answers to these queries. Do you wish to have an article contest in 1947? What topics do you suggest? Address your letters to: The Canadian Nurse, 522 Medical Arts Building, 1538 Sherbrooke St., W., Montreal 25, P.Q.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Le Lit Orthopédique

SOEUR MARIE-AUXILIATRICE, O.S.A.

DESCRIPTION

Le LIT LUI-MEME est le lit simple d'hôpital sauf qu'il est un peu plus long; il doit mesurer sept pieds. Il requiert un matelas ferme, sous lequel on glisse une planche dans la plupart des cas afin de le maintenir rigide.

L'appareil orthopédique, que l'on peut adapter à tous les lits, est pourvu de différents accessoires de manipulation très facile. La charpente comprend deux supports de fer maintenus par des traverses de bois et fixés au lit au moyen de courroies de cuir. Détail pratique: à leur partie supérieure, ces supports sont légèrement incurvés pour éviter de détériorer le mur en déplaçant le lit.

Sur cette charpente viennent s'ajuster les accessoires. Le plus important est le cadre "Bradford,"*
genre de brancard. Sur le cadre luimême sont fixés deux bandes d'un
canevas spécial, retenues à chaque
extrémité et au centre par des lacets
de cuir pour les maintenir bien tendues. Ces quatre tubes de fer peuvent
être facilement désunis, pour nous permettre de retirer les canevas pour la
lessive. Des cordes, retenues par quatre
crochets, supportent le brancard et
permettent le jeu de poulies doubles,
qu'une simple manette fait mouvoir.

Un trapèze, placé à portée de la main du malade, est suspendu aux traverses de bois sur lesquelles sont fixées des poulies, selon les besoins.

*Pour catalogue s'adresser à Zimmer ou De Puy, Warsaw, Indiana, U.S.A. Une autre barre transversale, munie d'une poulie, peut fort bien s'ajouter au pied; elle servira pour faire l'extension d'un membre inférieur.

AVANTAGES

Ce lit offre de précieux avantages tant à la garde-malade qu'au malade lui-même.

Les fractures de la colonne et du bassin sont assurément les cas qui présentent le plus de difficultés et qui bénéficieront surtout de ce lit; aussi bien que tout opéré à la suite d'une intervention sur la colonne soit greffe ou laminectomie.

Le premier avantage est celui du cadre "Bradford," et il est pour le malade. Il lui évitera des mouvements douloureux, soit au cours des soins quotidiens, d'un traitement, soit pour son déplacement du lit sur la civière, s'il s'agit d'examens radiologiques ou autres. Il suffit de décrocher et de glisser le cadre sur le véhicule. La position du malade n'a pas changé et il n'a subi aucun contrecoup.

L'infirmière dépense ses forces et se voit malgré tout obligée de lancer un S.O.S. Ici, sa tâche est bien diminuée. J'ai moi-même soulevé une malade immobilisée, pesant environ 170 livres, sans dépenser deux calories. Juste un petit coup de manette et tout était fait

TECHNIQUE

Pendant qu'un malade est à la salle d'opération, l'infirmière s'occupe de faire placer le cadre sur la voiture qui

43

doit le ramener à son lit. Après l'intervention, le malade y sera déposé avec toutes les précautions nécessaires par le personnel de la chirurgie. Sa position maintenant définitive rassurera l'orthopédiste.

Pour les cas de fracture de la colonne et de mal de Pott, le cadre n'a plus son plan horizontal droit, mais il présente une convexité au niveau de la région dorso-lombaire, afin de maintenir le malade en hyperextension

dorsale.

Pour diminuer la pression sur le matelas et prévenir les plaies de décubitus, on place sur ce brancard spécial deux coussins faits de coton hydrophile recouverts de gaze. Ces coussins sont protégés par deux alèzes. Dans les cas de greffe de la colonne, ces alèzes serviront à mouvoir le patient dont la position doit varier aux six heures et toujours sans préjudice au succès du traitement.

Mais le malade n'est pas seul à bénéficier de cet appareil dont les avantages

sont incontestables.

L'arrivée d'un cas de fracture de la colonne ou du bassin dans un de nos services de chirurgie rend perplexe la plupart de nos meilleures infirmières. Oui ne connait la difficulté des soins à donner, les dangers d'une immobilisation trop prolongée, et pardessus tout la crainte de nuire à la formation du cal osseux par des déplacements trop brusques? Rien que pour maintenir confortablement un membre fracturé dans la position requise, cela demande beaucoup d'habileté de la part de l'infirmière. Le lit orthopédique vient au secours des bonnes volontés. Il est l'auxiliaire le plus commode et le plus précieux. Son mécanisme, en assurant au malade un maximum de sécurité, facilite extraordinairement la tâche de l'infirmière. Le cadre "Bradford" laisse toute liberté pour les traitements, permet de donner des soins hygiéniques plus fréquents et plus suivis, grâce à l'espace ménagé au centre, entre les deux bandes de canevas.

L'entretien du lit est grandement simplifié, le malade étant isolé du lit au moyen du brancard. De plus, elle a la satisfaction de sentir qu'elle n'incommode ni ne fatigue son malade pendant tout le temps que durera le procédé.

Pour déplacer l'un de ces grands malades dans un lit ordinaire, il faut

vraiment faire de l'acrobatie.

S'il s'agit de fracture du bassin. accident qui se rencontre souvent chez les personnes âgées, l'infirmière mettra tout en oeuvre pour entretenir les mouvements chez ces malades dont l'immobilisation prolongée favorise les stases et entraîne soit des complications pulmonaires, embolies ou autres. C'est ici que le trapèze prouve son utilité. Il permet au malade de prendre des positions confortables, de se supporter seul, de s'aider en maintes circonstances. Ce qui redonne du tonus musculaire, de la souplesse et fait disparaître les oedèmes en activant la circulation.

Chez un fracturé, immobilisé dans un plâtre, les mouvements étant nécessairement limités, l'infirmière suppléera à cette déficience en tournant le malade sur l'abdomen, une heure l'avant-midi et une heure l'après-midi.

On peut maintenir un membre soulevé, soit à l'aide de coussins ou encore en le suspendant par la poulie à la traverse, au moyen de bandes de canevas fixées préalablement dans le bandage plâtré par l'orthopédiste.

Dans les cas d'arthroplastie de la hanche et du genou, après l'enlèvement du plâtre, il faut procéder graduellement à la rééducation des mouvements. Un support, lequel placé sous le genou et maintenu par une corde munie d'une poignée, permet au malade des mouvements actifs de ses membres supérieurs et, comme conséquence, des mouvements passifs des membres inférieurs. Cet exercice aura pour effet indirect de combattre un état de dépression, compagnon fatal, souvent, des maladies longues, et de jouer le rôle d'occupation thérapeutique.

Il y aurait aussi intérêt à utiliser ces lits chez les paralysés et les impotents. Comme mesure prophylactique des plaies de décubitus chez les personnes maigres, on laissera entre le cadre et le lit un léger espace qui permettra d'y glisser des coussins.

Notes from National Office

International Council of Nurses

FOR THE FIRST TIME since 1937, the Quadrennial Congress of the International Council of Nurses will be held in Atlantic City, N.J., May

11-16, 1947, inclusive.

Previous to the Congress in Atlantic City, the Board of Directors and the Grand Council of the I.C.N. will meet in Washington, D.C., May 4-10, 1947. The Board of Directors will meet May 5 and 6 for a business meeting. Each member country is entitled to send the president of the national association to that meeting. Also, it is quite possible that the executive secretary of each national organization will be asked to attend, pending the decision made at the Board of Directors meeting held in London, in September, 1946. The president, treasurer, executive-secretary, and chairmen of all committees will make their reports at this meeting. Resolutions from national organizations should be placed on the agenda and, after the approval by the Board of Directors, will be transmitted to the Grand Council for adoption.

The Grand Council will meet May 7, 8, and 9. At this meeting, the election of international officers will take place—one president, three vice-presidents, and a treasurer. Reports from the Board of Directors will be presented. General policies and work for the next quadrennial period will be outlined. All national organizations will be asked to present reports on their activities not later than January 1, 1947, as they must be translated and printed to be at the disposal of

the delegates.

The Grand Council consists of international officers, national presidents, and four official delegates from

each country, and one delegate from associate national representatives. On May 10, all official delegates will leave Washington, D.C., for Atlantic City,

N.I.

The Quadrennial Congress will take place in Atlantic City, starting Sunday, May 11, and will be opened by two church services—one Catholic, one Protestant. The rest of Sunday will be used for registration. The Congress will begin with a general meeting on Monday, May 12. More details about the program will be available at a later date from the American Nurses' Association, who is hostess to the International Congress.

On Saturday, May 17, the new Board of Directors, presided over by the newly-elected president, will have

its first meeting.

The Swedish Nurses' Association has sent an invitation to the International Council of Nurses to hold its next meeting (following the Congress

in 1947) in Stockholm.

All registered nurses are cordially invited to attend the meetings of the International Congress. Identification cards as registered nurses (or proof of membership in a national organization) will be the only document necessary to register for the Congress and to participate in all the activities. The number of registered nurses will not be limited. Student nurses are also invited. However, their number must be limited to one representative from each school of nursing. In addition to student nurses, who will be welcomed as special guests, a certain number of other special guests are invited, such as doctors, those in allied professions, and those especially interested in the nursing profession.

JANUARY, 1947 45

American Nurses' Association

Each person attending the biennial convention of the A.N.A. held in Atlantic City, N.J., September 23-27, will have her own story to tell, as it was quite impossible to take in all the meetings and conferences. The best we can do is to try to tell in our own way some of the highlights of the meetings.

Of far-reaching significance was the decisive vote by the House of Delegates, authorizing State and District Associations to act as exclusive collective bargaining agents for American

nurses.

The report on the structure of organized nursing (see A.J.N. Oct. and Nov. 1946) was one of the most important items on the agenda. This is a long range program and nurses are urged to study and discuss the report since the implications of its two suggestions for the new structure are so far-reaching.

A great deal of the discussion of personnel policies and practices as related to nurses was of pertinent interest to all nurses. Not only was the necessity for written policies of salary, hours, work, and other activities discussed, but job analysis, recognition of tenure of office and for outstanding work was also fully dis-

cussed.

Fees were raised from 75 cents per capita to \$3.00 per capita by more than two-thirds majority vote. The N.L.N.E. annual dues for individual membership were raised to \$5.00.

The House of Delegates voted a revision of by-laws making proxy voting possible. In the future, elected delegates who are unable to attend the convention will have their personally marked ballots deposited in the ballot box at the convention by proxy, thus making it possible for a State Association to use all the ballots to which it is entitled.

The House of Delegates approved a motion: "That coloured nurses who are not eligible for membership in their State Nurses' Association be made eligible for membership in the A.N.A."

The president gave the following

ten points as a suggested platform for the coming biennium:

- 1. Improvement in hours and living conditions for nurses, so that they may live a normal personal and professional life, specifically action toward: (a) Wider acceptance of the 40-hour week with no decrease of salary, thus applying to our post-war conditions the principle of the 8-hour day adopted by the American Nurses' Association in 1934. (b) Minimum salaries adequate to attract and hold nurses of quality, and to enable them to maintain standards of living comparable with other professions.
- 2. Provision for optimal nursing care for all, and furtherance of a positive health program in all communities.
- 3. Increased participation by nurses in the actual planning and in the administration of nursing service in hospitals and other types of employment.
- 4. Greater development of nurses' professional associations as exclusive spokesmen for nurses in all questions affecting their employment and economic security. Such a development should be based on past successful experience of professional nurses' organizations in collective bargaining and negotiation.

The economic security program referred by the A.N.A. Advisory Council (September 22,1946) to the A.N.A. House of Delegates follows:

"The American Nurses' Association believes that the several State and District Nurses' Associations are qualified to act and should act as the exclusive agents of their respective memberships in the important fields of economic security and collective bargaining. The association commends the excellent progress already made and urges all State and District Nurses' Associations to push such a program vigorously and expeditiously.

"Since it is the established policy of other groups, including unions, to permit membership in only one collective bargaining group, the association believes such policy to be sound for the State and District Nurses' Associations."

- 5. Removal, as rapidly as possible, of barriers that prevent the full employment and professional development of nurses belonging to minority racial groups.
- 6. Employment of well-qualified practical nurses and other auxiliary workers under state

licensure, thus protecting both the patient and the worker.

- 7. Continuing improvement in the counselling and placement of nurses, to give greater stability and job satisfaction to the profession and to facilitate a better distribution of nursing service to the public.
- 8. Further development of nursing in prepayment health and medical care plans, in order to spread the cost of nursing service to the public.
- 9. Maintenance of educational standards, and development of educational resources, that nursing may keep abreast of the rapid advances in medicine and other sciences. Such development may well require federal subsidies and contributions from foundations and other educational philanthropies.

10. Appraisal of our own national organizations, through the report of the Structure Study, and fearless action based upon such appraisal, to make sure that the nursing profession will be organized and equipped to deal most effectively with its problems and its opportunities.

In conclusion: If the nursing profession is ready to take decisive action on hours, salaries, economic advancement, enlargement of nursing resources while maintaining standards and the possible reconstruction of its own organizational structure, we shall have made nursing history this week.

Provincial Registered Nurses' Associations

Progress reports as presented at the Executive Meeting, C.N.A., December 5-7, 1946, follow:

Alberta Association of Registered Nurses: In Alberta, revision of the Alberta Registered Nurses Act has begun. The Educational Policy Committee has been appointed with Miss Helen Penhale as convener. The main topics that are being studied by this committee are: (a) The possibility of expanding affiliations for Alberta student nurses so as to include experience in tuberculosis and psychiatric hospitals and possibly in selected approved rural hospitals. (b) The possibility of a Central School of Nursing in order to increase the number of nurses graduating each year in Alberta and improve and facilitate the education of student nurses. (c) The arrangement of short courses in examination technique and relative matters.

A brief was prepared and sent to the Department of Health relating to the Alberta Health Insurance Act.

The instructors' group is revising the "Minimum Curriculum for Schools of Nursing in Alberta." One dollar per capita of the 1946 registration fee of five dollars is being used to assist in financing the nurse placement service.

Registered Nurses' Association of British Columbia: In British Columbia, the five larger schools obtained the number of students for which they planned, the two larger schools reporting more acceptable applicants than could be enrolled.

The present vacancies in public health, schools of nursing, hospitals and institutions amount to 439.

More than thirty employers have notified Placement Service that all or nearly all of the recommendations have been put into effect or are under consideration at the present time.

A series of bulletins on Employer-Employee Relationships for distribution to members of the nursing staff in hospitals, institutions, clinics, visiting nursing, and public health nursing agencies is being prepared by a sub-committee of the L.R. Committee.

A Joint Planning Committee on Nursing was organized in August representing the Departments of Education, Health and Welfare, Inspector of Hospitals, D.V.A., Medical and Hospital Associations, Community Chest and Welfare Council, and the R.N.A.B.C. A sub-committee was appointed to plan an activity analysis within hospitals and outline training courses. The chairman selected a fact-finding committee from hospital personnel to report on the type of non-professional workers now employed in hospitals: what duties are now being carried on by these workers and of what further duties could nurses be relieved.

The sub-committee was authorized to proceed to outline details of the training program.

Manitoba Association of Registered Nurses: In Manitoba, two nurse-members have been appointed to a committee set up by the Minister of Health and Public Welfare for the purpose of studying the "Training of nurses and the supplying of personnel suitable for rural hospitals."

An instructors' institute was held in June at the University of Manitoba. Discussion and revision of the content of courses tested in qualifying and registration examinations were the chief topics. Revisions were made in the curriculum outline for first year and senior students.

Deep concern was expressed at a meeting of the Joint Committee on Tuberculosis Nursing over the fact that registered nurses were not willing to do nursing in tuberculosis.

The New Brunswick Association of Registered Nurses, through the Committee of the Subsidiary Worker, seeks the support of selected community organizations in the proposed licensing of the subsidiary worker and urges that further study be made of the bill for licensing the subsidiary worker and that a special meeting of the executive council be called later to study and further implement the bill.

The annual membership fee was raised to \$5.00.

A study of the proposed revision of the present Constitution and By-laws for the Registered Nurses' Association of Nova Scotia was authorized by the association to the incoming Legislative Committee.

It was proposed at the annual meeting that branches of the R.N.A.N.S. endeavor to form Public Health and Welfare forums in their localities for the purpose of stimulating interest and assisting in the solution of nursing problems.

The members of the *Prince Edward Island Registered Nurses Association* have already begun work on the revision and amendments to their Constitution and By-laws. Personnel practices and policies for the General Nursing Section have been prepared and a library established by the Public Health Group.

The main concern of the Committee of Management of the Registered Nurses Association of the Province of Quebec is the planning of all the various changes in policy and administration which the licensing Act calls for.

The Committee on Subsidiary Nurse Workers has held three meetings. As a result, a study committee has been organized for the purpose of submitting a license plan for consideration of the larger group.

The place of the subsidiary worker, etc., and present scales of staff salaries in hospitals were discussed at a meeting with representatives of the three hospital councils of the province. Fees have been raised to six dollars. It is generally understood that the increased activities of the labor syndicates, insofar as their endeavors to involve nurses are con-

cerned, is due to the fact that, after December 31, 1946, nurses will be legally classed as professional workers.

The Saskatchewan Registered Nurses' Association, through the Joint Committee, is studying ways and means of securing cooperation in directing the efforts of the registered nurse to professional duties only, of securing more professional nurses, and of obtaining governmental support for schools of nursing.

First year qualifying examinations have been approved by the senate of the University of Saskatchewan and are to go into effect on January 1, 1947.

Uniform policies for all schools of nursing in Saskatchewan covering fees, uniforms, monthly allowances, and length of preliminary period have been agreed upon. The preliminary period will be extended to six months for students entering a school of nursing on or after January 1, 1947. Under these regulations it has been agreed that student nurses in Saskatchewan will be exempt from the Minimum Wage Act.

The provincial government has given a grant for 1946-47 to support the development of the Nurse Placement Service in Saskatchewan.

Parcels for Great Britain and War-Devastated Countries

The International Council of Nurses has given out many names of nurses in war-devastated countries to whom Canadian and American nurses sent individual parcels of food and clothing. Letters of thanks and appreciation have been received by the senders in many cases. However, there are many nurses who have not received such letters and who are, naturally, disappointed. In some cases either the parcel or the letter of thanks may have been lost, or the sender's name may have become illegible or have been torn off the parcel by the recipient in the first excitement over the gift. It is, therefore, suggested that all senders of parcels put a card with their name and address, IN PRINT, inside each parcel and that they follow up the parcel with a letter announcing the parcel and asking for an acknowledgement. It could also be stated that no further parcels would be sent if no acknowledgement was received. It is also extremely important to use strong corrugated cardboard boxes and wrapping paper, since many parcels get lost because they are crushed or otherwise damaged and the paper torn off.

It is hoped that unfortunate experiences will not discourage nurses in the more fortunate countries from sending parcels to their suffering colleagues who always appreciate any useable gift of food or clothing and who feel deeply grateful for them. We also suggest that the names of nurses who do not acknowledge parcels be sent back to I.C.N. headquarters or to the C.N.A. in order that steps may be taken to contact the nurse in question.

Finally, we would like to remind senders of parcels that to most European countries packages still take an average of three months and that letters, if they are not sent air mail, take almost six weeks.

Notes du Secrétariat de l'A.I.C.

CONSEIL INTERNATIONAL DES INFIRMIERES Pour la première fois depuis 1937, il y aura réunion du conseil international des infirmières. Ce congrès, qui normalement a lieu tous les quatre ans, aura lieu à Atlantic City, N.J., du 11 au 16 mai 1947. Il v aura, au préalable, réunion d'affaire à Washington des membres du bureau, du 5 au 6 mai, et des membres du grand conseil de C.I.I. du 7 au 9 mai: à cette assemblée il v aura élection des dignitaires du bureau des directeurs. Le bureau des directeurs se compose d'une présidente, de trois vice-présidentes et d'une trésorière, élues par le grand conseil qui se réunit tous les quatre ans. Le grand conseil se compose des membres du bureau des directeurs, des présidentes des associations nationales, de quatre déléguées pour chaque pays, et d'une déléguée choisie parmi les membres de l'association nationale.

A l'assemblée du grand conseil à Washington, il se peut que le secrétaire de chaque association nationale soit invitée; cette suggestion a été faite lors de l'assemblée du bureau des directeurs, qui eut lieu à Londres en septembre 1946. Les rapports des présidentes, secrétaires, et trésorières de tous les comités devront être présentées lors de cette réunion. Les résolutions soumises par les associations nationales devront être inscrites sur l'agenda. Une fois ces résolutions approuvées par le bureau des directeurs, elles seront soumises au grand conseil pour adoption.

Lors de la réunion du grand conseil, l'on

exposera la politique du C.I.I. et le travail à faire durant les quatre années à venir. L'on demandera à toutes les associations nationales de présenter leurs rapports avant le 1er janvier 1947. Ces rapports doivent être traduits et imprimés avant d'être présentés aux déléguées. L'ouverture du congrès international se fera dimanche, le 11 mai, et débutera par un service religieux qui aura lieu dans une église catholique et dans une église protestante. Les inscriptions seront recues durant le reste de la journée. Lundi, le 12 mai, il y aura une assemblée générale. Les détails du programme seront donnés par la "American Nurses' Association" qui recoit le congrès international. Samedi, le 17 mai, le nouveau bureau des directeurs aura sa première réunion.

L'Association des Infirmières de Suède a invité le C.I.I. à tenir le prochain congrès (après celui de 1947) à Stockholm.

Toutes les infirmières enregistrées sont cordialement invitées à assister au congrès international. La carte d'enregistrement, ou la preuve que vous êtes membre d'une association nationale, sera le seul document demandé pour votre inscription comme membre du congrès international et celà vous donnera droit de prendre part à toutes les séances et fonctions.

Les infirmières étudiantes sont aussi invitées mais on doit en limiter le nombre à une représentante par école. En plus des élèves infirmières, d'autres personnes seront reçues comme invités spéciaux, des médecins, des personnes de profession, ou des personnes particulièrement intéressées à la profession d'infirmière.

AMERICAN NURSES' ASSOCIATION

Il nous est impossible de donner un rapport de toutes les assemblées et conférences qui ont eu lieu lors du congrès de la "American Nurses' Association" du 23 au 27 septembre 1946; nous nous contentrons de signaler les faits principaux.

La décision prise par les déléguées d'autoriser les associations de chaque état et les associations divisionnaires d'être les agents mandataires exclusifs pour les infirmières aura une grande répercussion.

La structure de la nouvelle organisation du nursing fut l'objet d'un rapport des plus intéressants et fut marquée sur l'agenda comme l'un des sujets les plus importants. (Voir l'American Journal of Nursing, oct. et nov. 1946.). Chaque infirmière est priée d'étudier avec soin ce programme puisque les deux suggestions qui y sont faites ont une grande portée et auront une non moins grande répercussion sur la profession. Dans les relations entre employeurs et employées il y a eu beaucoup de discussion concernant la ligne de conduite suivie à l'égard des infirmières. Il est non seulement nécessaire d'avoir par écrit l'échelle des salaires payés par l'institution ou l'organisation, mais en plus les heures et conditions de travail, etc. En plus l'on discuta de la nécessité d'analyser le travail, les obligations que chaque position comporte, et les qualifications requises de la part de l'infirmière désirant obtenir cette position; l'on discuta aussi des années de service et du travail sortant de l'ordinaire.

Le programme suivant fut tracé pour les deux années à suivre:

- 1. Amélioration dans les heures et les conditions de travail pour les infirmières afin qu'elles puissent avoir une vie personnelle aussi bien que professionnelle normale; pour atteindre ce but que chacune travaille: (a) à faire accepter plus généralement la semaine de 40 heures, sans diminution de salaire, applicant aussi le principe de la journée de 8 heures déjà adopté par la "American Nurses' Association" en 1934; (b) à ce que le salaire minimum soit suffisant pour attirer et garder les bonnes infirmières tout en leur permettant de vivre aussi bien que les membres des autres professions.
- A ce que l'on prenne les mesures nécessaires pour assurer les meilleurs soins, pour tous, en cas de maladie et qu'en plus un pro-

gramme de santé, bien défini, soit établi pour tous les milieux.

- A ce que les infirmières prennent une plus grande part dans l'organisation et l'administration des services de santé, des hôpitaux et autres services du même genre.
- 4. A ce que l'on demande de plus en plus l'intervention d'association professionnelle d'infirmières comme porte-voix des infirmières pour tout ce qui concerne leurs emplois et la sauvegarde de leurs intérêts. Ce service se développera en raison des succès obtenus par les associations professionnelles comme agent mandataire et dans les contrats collectifs.

Voici le texte de la recommendation faite par le comité des aviseurs aux déléguées de l'A.N.A. (sept. 22 1946):

"La 'American Nurses' Association' croit que dans plusieurs états les associations d'infirmières de l'état et des associations divisionnaires ont qualité pour agir, et doivent agir, comme agent exclusif chargé de représenter leurs membres dans le domaine important des questions économiques et dans les contrats collectifs. L'association commenta les progrès déjà réalisés et recommenda à toutes les associations d'états et de districts de pousser immédiatement et avec vigueur ce mouvement."

- 5. Que l'on enlève toutes entraves empêchant de donner à un groupe minoritaire d'une race un développement professionnel complet et d'accès à toutes les positions.
- 6. Que l'on emploie des aides-malades bien préparées et d'autres aides; que toutes obtiennent une licence de l'état afin que le public aussi bien qu'elles-mêmes soient protégés.
- 7. Que les bureaux de placement soient continuellement améliorés afin d'assurer à l'infirmière un travail plus stable, plus satisfaisant, et afin de faciliter une meilleure distribution du service d'infirmières.
- 8. Afin que le nursing soit en marge des progrès accomplis par la médecine et les autres sciences, que le niveau de l'instruction soit maintenu, et que toutes les ressources éducationnelles facilitant la formation de l'infirmière soient développées. Le développement de ces ressources éducationnelles peut nécessiter l'aide financier du gouvernement fédéral, des contributions de fondations et d'autres sociétés philanthropiques.

Résumé: Si la profession d'infirmière est prête à prendre une ferme décision concernant les heures de travail, les salaires, le progrès économique, étendre le nursing tout en maintenant les standards et à considérer la réorganisation de la structure professionnelle, la "American Nurses' Association" aura écrit durant cette convention une page de l'histoire de la profession.

Les Associations Provinciales, A.I.C. Alberta: L'on est à reviser la loi des infirmières de l'Alberta. Un comité d'éducation a été nommé; Mlle H. Penhale en est la convocatrice. Les sujets suivants ont été étudiés par ce comité:

- (a) La possibilité d'augmenter les affiliations pour les élèves des écoles d'Alberta, afin qu'elles aient de l'expérience en tuberculose et en psychiatrie et aussi dans les petits hôpitaux ruraux préalablement choisis et approuvés.
- (b) La possibilité de la création d'une école centrale d'infirmières, afin d'augmenter le nombre d'infirmières diplômées chaque année en Alberta et aussi afin de faciliter et améliorer la formation desélèves infirmières.
- (c) L'organisation de cours de courte durée sur la technique des examens et autres questions s'y rapportant. Un mémoire sur la loi des Assurances de Santé de l'Alberta fut préparé et envoyé au Ministère de la Santé. Les institutrices sont à reviser le programme minimum des écoles d'infirmières d'Alberta.

Afin de venir en aide aux bureaux de placement, on leur a attribué \$1.00 de la contribution annuelle de \$5.00.

Colombie Britannique: Les cinq plus grandes écoles d'infirmières ont reçu toutes les élèves qu'elles pouvaient loger: deux grandes écoles ont reçu plus de demandes qu'elles pouvaient en accepter. L'on compte 439 vacances dans les écoles d'infirmières hygiénistes, dans les hôpitaux et les institutions.

Plus de trente employeurs ont prévenu le bureau de placement des infirmières que toutes ou presque toutes les recommendations qui leur ont été faites ont été exécutées ou sont actuellement sous considération.

Une série de bulletins sur les relations entre employées et employeurs, préparés par un sous-comité du comité des relations ouvrières, seront distribués aux infirmières dans les hôpitaux, institutions, cliniques, aux infirmières visiteuses, et aux infirmières aux services d'hygiène et de santé.

Un comité conjoint sur l'organisation du nursing fut formé en août: il est composé de représentants du ministère de l'Education, de la Santé et du Bien-Etre social, de la Fédération des Oeuvres de Charité, et de l'Association des G.M.E. de la Colombie Britannique. Un sous-comité s'occupera de préparer un plan dans le but d'analyser le travail à l'hôpital et les programmes d'étude. Le président a choisi, parmi le personnel des hôpitaux, un comité chargé de faire rapport sur les personnes n'ayant aucune formation professionnelle travaillant dans les hôpitaux; quel travail font actuellement ces personnes et quel autre travail pourraient-elles faire pour diminuer le travail de l'infirmière.

Manitoba: Deux infirmières furent nommées par le ministre de la Santé et du Bien-Etre social sur un comité chargé d'étudier: "Le cours d'infirmière et comment assurer aux hôpitaux ruraux un personnel convenable."

Les institutrices se sont réunies en juin à l'Université du Manitoba. Il y eut discussion sur le programme d'étude, sa valeur à la lumière des résultats obtenus aux examens. L'on revisa le programme de la première année du cours. Le comité conjoint du nursing en tuberculose fit rapport que les infirmières enregistrées ne veulent pas faire du service chez les tuberculeux.

Nouveau-Brunswick: L'on fait actuellement l'étude d'un projet de loi qui accorderait une licence aux aides-malades. La contribution annuelle pour l'enregistrement est maintenant de \$5.00.

Nouvelle-Ecosse: L'Association des Intirmières de la Nouvelle-Ecosse a autorisé son comité de législation à étudier les lois et règlements de l'association dans le but d'une revision. A l'assemblée annuelle il fut proposé que des débats sur la Santé et le Bien-Etre soient organisés dans le but de stimuler l'intérêt et d'aider aussi à la solution de quelques problèmes du nursing.

Ile du Prince Edouard: L'on travaille à la revision des lois et règlements.

Québec: Notre plus grande préoccupation actuellement est la préparation des règlements conformément aux exigences de la nouvelle loi. Il y aura aussi des changements dans l'administration.

Le comité des aides ou auxiliaires s'est réuni trois fois; comme résultat un comité d'étude fut nommé dont le but est de soumettre un projet de licence, projet qui sera étudié par un groupe plus important. Le rôle de l'aide, etc., l'échelle des salaires dans les hôpitaux furent des sujets étudiés par trois conseils d'hôpitaux de la province. La cotisation a été augmentée à \$6.00.

L'intérêt montré soudainement par les syndicats ouvriers envers les infirmières est dû au fait qu'à partir du 31 décembre 1946, infirmières seront légalement reconnues comme infirmières professionnelles.

Saskatchewan: L'Association des Infirmières de Saskatchewan par son comité conjoint étudie les moyens à prendre pour obtenir des infirmières enregistrées, qu'elles ne fassent que du travail professionnel, pour avoir un plus grand nombre d'infirmières professionnelles, pour obtenir des subsides du gouvernement pour les écoles d'infirmières.

Les examens d'enregistrement de la première année ont été approuvés par le conseil des études de l'Université de Saskatchewan et seront en vigueur à partir en 1947. Les écoles d'infirmières de la Saskatchewan se sont entendues pour qu'il y ait uniformité de droit d'entrée, dans la rémunération mensuelle, l'uniforme, la durée du cours préliminaire. Le cours préliminaire sera de six mois pour les élèves admises à une école le ou après le 1er janvier 1947.

Les élèves étudiantes, à la suite de cette entente, ne seront pas soumises à la loi du salaire minimum.

Le gouvernement de la Saskatchewan a donné un octroi pour aider au développement des bureaux de placement des infirmières de la Saskatchewan.

Annual Meeting in New Brunswick

The thirtieth annual convention of the New Brunswick Association of Registered Nurses was held in Trinity Church Vestry, St. Stephen, on September 25 and 26, 1946. Following the invocation by Rev. A. R. Smith, Rector of Trinity Church, a gracious welcome was extended to the guests by the mayor of St. Stephen. Messages of greeting were read by the secretary.

With a registration of 135, we felt we had a good representation, considering the crowded conditions of the hospitals. There were members from all branches — superintendents of nurses, instructors, head nurses, private duty and public health, and among these was a goodly number of the younger nurses who showed a keen interest in the proceedings which bodes well for the future of the association.

The president, Miss M. Myers, presided at all sessions. In her presidential address she reminded the members of the need to study seriously what is going on in nursing today and to ask themselves why certain things come about and whether we, as individuals, have any responsibility in the matter whatsoever. Shortage of nurses is, of course, uppermost in the minds of everyone as it is evident in all types of nursing and the question is asked: Are the members doing their best to relieve this acute shortage by fullest co-operation with institutions and individuals requiring nursing service?

This year all reports were compiled in

pamphlet form previous to the meeting and each member received a copy on registration. The executive secretary covered the work of the association for the past year, as carried on in the provincial office. pital expansion is being carried out as rapidly as possible in almost every locality. This included hospitals with training schools, small private hospitals, as well as outpost hospitals sponsored by the Red Cross. The same difficulty confronts us there in finding nurses to staff these hospitals, but by some means or other the work is being done, perhaps not quite as well as we would like, but at least the patients are being cared for. In view of the acute shortage of nurses temporary, or courtesy, registration is being granted for another year to nurses remaining in the province less than a year, and to those not meeting the requirements of our registration

Legislation: The proposed Constitution and By-laws of the Canadian Nurses' Association were presented by the convener of Legislation, Miss H. Bartsch, and discussed in detail. A resolution for the acceptance of the Constitution and By-laws, including amendments submitted from the biennial convention, was adopted.

Chapter reports showed a busy year, each chapter making their meetings as interesting as possible by having speakers on different subjects.

Dr. J. A. Melanson, Deputy Minister of

Health, gave an interesting and stimulating address on the present and future program of his department. The set-up is a beginning of widespread plans for the health of the public. He touched on the increased number of beds available for tuberculosis patients; the poliomyelitis clinic in Fredericton; the cancer clinic in Saint John, and the prospect of more public health doctors and nurses in the field.

Following this a report on the proposed licensing of the subsidiary nurse was presented by the convener, Miss Hunter. A school for trained attendants was opened in Moncton in July under the sponsorship of the C.V.T. It is hoped that the licensing bill, as submitted under the Department of Health, will be approved by the time these workers are ready for placement. A long discussion took place regarding this.

Special events of a delightful character were: A tea given by the St. Stephen Chapter at the end of the first day's sessions. In the evening a banquet was held at which Mr. Stuart Trueman, associate editor of the Telegraph-Journal, Saint John, was guest speaker. He gave a very interesting talk on the work of the press and its responsibility in maintaining an informed public. On the final day of the meeting we were again entertained at luncheon by the St. Stephen Chapter when the nurses had an opportunity to meet informally.

The three sections held their meetings concurrently on the morning of the second day.

The Public Health Section had a very active year; a new sub-section of the provincial section was formed during the year. This sub-section is so near the Nova Scotia border that nurses from the two provinces are able to meet together which makes it a most interesting set-up.

Hospital and School of Nursing Section: A committee was appointed to continue the preparation of our minimum curriculum for use in all the schools of the province with the object of having first-year qualifying examinations. The N.B.A.R.N. went on record as supporting the resolution regarding the educational standard for schools of nursing as submitted by the Canadian Nurses' Association. A letter is to be sent to each superintendent of nurses in the province advising her of this resolution.

From the General Nursing Section report came many matters for discussion; it was urged by the convener that general duty nurses be invited to nurses' staff meetings, to bring about better co-operation between the two bodies. Again the matter of nurses wearing uniforms on the streets was discussed from several angles. The association went on record as disapproving of the wearing of uniforms on the street except on official occasions. The general nursing fees were increased to: 8-hour duty, \$5; 12-hour duty, \$6; 20-hour duty, \$7.

The Canadian Nurse: Letters have been sent to nurses whose subscriptions have lapsed and contacts made with nurses who have never subscribed to the Journal. One hundred and seventy-five new subscriptions were received during the year.

Nurse Placement Service: This service has now been in operation for two years and is carried on at the provincial office. The shortage of nurses makes it difficult to function as we would like, but it is felt it will be much more useful in the future. About 25 per cent of the requests for nurses in institutions and public health have been met.

A brief was presented by a committee from the Maritime Hospital Association in an effort to secure nursing service in tuberculosis sanatoria. It was recommended that publicity be given through the press and radio to dispel the fear that is apparent in the minds of parents as well as candidates concerning tuberculosis nursing. Two other recommendations were: Since the services of trained attendants has proved of great value, That serious consideration be given to the continuance of the school for trained attendants in Moncton: and, That an attempt be made to secure affiliation for schools of nursing with sanatoria. A committee was appointed to study these questions and contact schools of nursing to see what could be done regarding affiliation.

Concerning Resolution No. 1, as submitted by the Canadian Nurses' Association:

That, due to a steadily growing and urgent demand for more nursing service, it was resolved that the Canadian Nurses' Association recommend to the Provincial Registered Nurses' Associations that they immediately form committees representative of all branches of nursing; that these committees proceed immediately to take whatever steps may be necessary to train a sufficient number of nurse-aides and that, in order to protect both the community and the workers, continued efforts be made to obtain licensing regulations for these auxiliary workers;

that since this necessary expansion in the supply of nurses is not solely the responsibility of hospitals, and since present educational facilities are not adequate to produce a sufficient quantity of the best quality of graduate nurses, efforts be made to secure Governmental support for schools of nursing.

This resolution was discussed and the following motion carried:

That the incoming executive be requested to study said resolution and be given power to formulate a special committee as recommended and, if deemed advisable, approach Governmental bodies concerned for financial assistance for schools of nursing.

The following slate of officers was pre-

sented and elected for 1946-48:

President, Marion Myers; first vice-president, Reta Follis; second vice-president. Hilda Bartsch; honorary secretary, B. M. Hadrill. Section chairmen: Hospital and School of Nursing, Sister Rosarie; General Nursing, Mrs. B. Nash Smith; Public Health, Lois Smith; Legislation Committee, Isabel Lane; *The Canadian Nurse*, Edna Henderson; councillors, Margaret Murdoch, Mabel McMullen, A. J. MacMaster, Sister Anne de Parede, M. E. Hunter.

An invitation was accepted from the Saint John Chapter to meet in Saint John in 1947. ALMA F. LAW

Secretary-Registrar

Annual Meeting in Ontario

The twenty-first annual meeting of the Registered Nurses Association of Ontario, held in Toronto at the Royal York Hotel on October 29, 30, 31, 1946, was opened by the president, Miss Jean I. Masten. The registration of 496, including 53 student nurses, was larger than at first anticipated as the Ontario Hospital Association convention had been held in Toronto the previous week. The president extended a welcome to all members, and especially to Miss Winnifred Cooke, assistant secretary, C.N.A. The association was very pleased that it was possible for Miss Cooke to attend the meeting and appreciated her assistance in giving further information in connection with some of the questions under discussion. The association was pleased to have as their guest, Miss Helen McArthur, chairman, Public Health Section, C.N.A. It was indeed fortunate for Ontario that Miss Ethel Johns was residing in Toronto and was so willing to assist on the program.

A folio of the reports to be presented was prepared for distribution to all who registered. The important questions discussed at the opening session on Tuesday afternoon included the amendments to the C.N.A. Constitution and By-laws, which were forwarded to the provincial associations following the biennial meeting, with the understanding that each association would have the right to express its approval or disapproval of the adoption of the

new Constitution and By-laws before November 15, 1946. The members attending the annual meeting had the privilege of voting by ballot during the hours of meeting. The result of the votes cast showed that the decision was against the adoption of the new Constitution and By-laws.

The program included two panel discussions. One entitled "Population Trends in the Community and their Effect on the Future of Nursing" was conducted under the chairmanship of Miss Edna L. Moore, assisted by Prof. V. W. Bladen, M.A., F.R.Sc., Department of Political Economy, University of Toronto, and director, Institute of Industrial Relations; Mr. H. E. Elborn, principal, Toronto Normal School; Miss E. Kathleen Russell, director, School of Nursing, University of Toronto; and Miss Ethel Johns, formerly editor of The Canadian Nurse. The second panel discussion on "The Changing Responsibilities of the Nurse with Respect to Modern Methods of Treatment and Rehabilitation" was conducted under the chairmanship of Miss N. D. Fidler and assisted by Dr. Roscoe R. Graham, F.R.C.S. (c), assistant professor of surgery, University of Toronto: Miss Nan Landon, private duty nurse, Ottawa; Miss Hilda Coates, instructor, Wellesley Hospital, Toronto; and Miss Jean Leask, assistant superintendent, Toronto Branch, Victorian Order of Nurses. The nurses were keenly interested in these panel discussions and the

attendance at each was approximately 750.

The annual dinner was held on Wednesday, October 30, when Miss Anna Schwarzenberg, executive secretary, International Council of Nurses, spoke on "Today and Tomorrow in International Nursing." The address given by Miss Schwarzenberg on the nursing situation in England and European countries as observed during her recent visits, as well as the announcement regarding the International Congress of Nurses to be held in Atlantic City in May, 1947, was listened to with keen interest by the 636 persons present.

The business meetings of the Hospital and School of Nursing and the Public Health Sections were held concurrently on Wednesday afternoon. These meetings were followed by a general meeting when Miss Edith Young, as chairman, conducted a round table discussion on "The Independent School of Nursing," Miss N. D. Fidler, professor, University of Toronto School of Nursing;

"Personnel Policies in the Field of Nursing,"
Miss Gladys Sharpe, director of Nursing
Education, McMaster University, Hamilton.

The business meeting of the General Nursing Section was held at 5 p.m. to enable private duty nurses who were on duty during the day to attend. This departure from the usual procedure proved so successful that the section decided to make the same plans for 1947.

The 1946 annual meeting was held in October due to the problem of hotel accommodation. However, it was the decision of the members that we return to the former policy of holding the annual meeting in the spring. The nurses of Hamilton extended an invitation which was unanimously accepted and arrangements have been made to hold the meeting at the Royal Connaught Hotel on April 23, 24, and 25, 1947.

MATILDA E. FITZGERALD Secretary-Treasurer

Meeting Health Needs of School Children

Public health and school departments need to work together so that the health program of the schools is co-ordinated with that of the community as a whole.

The health needs of school-age children are stated to be: (1) A safe, sanitary, healthful school environment. (2) Protection from infections and conditions which interfere with proper growth and development. (3) An opportunity to realize their potentialities of growth and development. (4) To learn how to live healthfully. (5) Teachers who are equipped by training, temperament, and health not only to give specific instruction but also to help them to mature emotionally.

Data are presented to show that these health needs are not being met. An efficient, effective health program for all children of a community will result only when: (1) The public departments of health and of education, as well as specialized personnel within each department, agree to the principle of co-ordination of health programs for school children, including the health program of the community and the health aspects of school programs. (2) Each agency and profession respects the contribution of the others. (3) The agencies agree to an administrative plan which will promote the most efficient and co-operative direction of the several phases of the program and the supervision of the several types of professional workers. (4) The professional workers of each agency are permitted to perform services in their professional fields for the best interest of all children. (5) Sufficient funds become available to carry out the program.

- California's Health

Worry thrives on concealment of its cause. It usually happens that when the cause is discussed frankly with some trusted person, the load of worry grows much lighter, if it does not disappear altogether.

Interesting People

The honor and responsibilities of being president of the Ontario Hospital Association have been conferred upon **Priscilla Campbell**, the second time in the history of the association that this position has been held by a woman, a nurse.

Miss Campbell has a sound background of administrative experience to fit her for this important role. She graduated from Royal Victoria Hospital, Barrie, Ont., in 1916. Her qualities of leadership were immediately manifest and she served successively as night supervisor, operating-room supervisor, and assistant superintendent of her home school of nursing, going in 1920 to Brockville General Hospital as superintendent. In 1922, Miss Campbell was appointed superintendent of the Public General Hospital, Chatham, Ont., where today she occupies the position of administrator.

Broadening her background for administrative work, Miss Campbell went to London, Eng., and had practical experience at St. Thomas, Guy's, St. Bartholomew's, and Bethlehem Royal Hospitals. She is a member of the American College of Hospital Administrators and Canadian representative on the Council of Public Relations of the American Hospital Association. She has been a member of the Board of Directors of the Ontario Hospital Association since 1923. She is on the Council of Nursing Education for Ontario, and past president of District 1 of the R.N.A.O. She is a member of



PRISCILLA CAMPBELL

the Women's Canadian Club, the Business and Professional Women's Club, and the Twentieth Century Club.

Added to her fine record of achievement and her knowledge of hospital management, Miss Campbell has our good wishes for a very successful term of office.

Of interest to many Canadian nurses will be the news that Mary P. Connolly was the recipient of the 1946 Elisabeth S. Prentiss National Award in Health Education. Miss Connolly is probably best known to health educators through her work as Director of Health Education, Department of Health, City of Detroit. She is a fellow of the American Public Health Association. She served as secretary of the Health Education Section of the A.P.H.A. for several years and became its chairman in 1939.

Miss Connolly, who holds her M.S degree from the University of Detroit, took her basic training in nursing at St. Agnes Hospital, Philadelphia. From 1911 to 1914 she was director of nursing education, St. Joseph Hospital, Reading, Penna. During World War I she instructed with the American Red Cross in Philadelphia from 1915 to 1918. In 1918 she joined the staff of the Detroit Department of Health. She was



Clevel and Health Museum

MARY P. CONNOLLY

director of health education, until 1943, for twenty-five years. Since 1942 she has been lecturer and director of health education, School of Public Health, University of Michigan. She is a member of Delta Omega, the honor society in public health.

The award was established in 1943 by Cleveland Health Museum for an individual or persons working in co-operation who have made outstanding contributions in the field of health education. The award is symbolized by a plaque and a citation which follows: "The Elisabeth S. Prentiss National Award in Health Education for 1946 is presented to Mary P. Connolly, M.S., R.N., Down-to-Earth Health Educator, Detroit Department of Health, 1918-43; University of Michigan, School of Public Health, 1943; by the Board of Trustees, Cleveland Health Museum on November 13, 1946,"

The capable, national chairman of the Committee on Institutional Nursing during this biennium is Reverend Sister Delia Clermont. Of French parentage, Sister Clermont was born in Saskatchewan, receiving her early schooling in Weyburn. She received her first class teacher's certificate from the Regina Normal School in 1926. In 1930, she commenced her training in the school of nursing of St. Boniface Hospital, Man. She served as head nurse on a medical ward before going to St. Louis University where she secured her degree of Bachelor of Science in Nursing Education. Returning to her home school, Sister Clermont was successively instructor, assistant superintendent and superintendent of nurses. Since 1943, she has been educational director of the school of nursing.

Sister Clermont is second vice-president of the Manitoba Association of Registered Nurses, and served as first vice-chairman of the Hospital and School of Nursing Section, C.N.A.

Ella Mae Howard has been appointed to the staff of the school of nursing of the University of Toronto, to administer and teach in the courses in clinical supervision.

Miss Howard was born in Ontario and received her early education in Alberta. After graduating from Calgary Normal School she taught in the public schools of Alberta for several years. In 1937 she graduated from the school of nursing of the Royal Alexandra Hospital, Edmonton,



SISTER DELIA CLERMONT

and in 1939 obtained her certificate in teaching and supervision from the McGill School for Graduate Nurses.

Since 1940 Miss Howard has been instructor at the Nicholls Hospital, Peterborough, Ont., assistant superintendent of nurses at the Regina General Hospital, director of nursing at Saskatoon City Hospital, and director of publicity and recruitment for the Alberta Association of Registered Nurses. In 1946 Miss Howard obtained her B.S.N.



ELLA M. HOWARD



THEODORA BERTRAND

degree from Western Reserve University, Cleveland.

Miss Howard's personality, preparation and breadth of experience make her a most valuable addition to the Toronto school.

Theodora R. Bertrand est une infirmière diplômée de l'Hôpital Notre-Dame. Après quelques années de service privé et de service pour la Metropolitan, elle accepta le poste de directrice de l'Hôpital Normand et Cross, aujourd'hui Hôpital privé de Trois-Rivières, et de l'école d'infirmières qui fut attachée à cet hôpital jusqu'en 1934.

Mlle Bertrand fut une élève du premier cours post-scolaire donné par l'Université de Montréal en 1924 et montra toujours un grand intérêt envers la profession.

La carrière de Mlle Bertrand porte la marque du plus grand dévouement. Ses anciennes élèves trouvèrent toujours en elle une conseillère dévouée et éclairée. Lors d'une fête intime, les médecins de cette institution, les anciennes élèves, et quelques amis se réunirent pour lui offrir un hommage de reconnaissance bien mérité.

Elizabeth McKee has retired from the post of night supervisor at the Hamilton General Hospital, Ont., the duties of which she has discharged with skill and unvarying devotion for the past twenty years. This much-loved nurse had hoped to retire some years ago but remained at her work during the urgent period of the war.

Miss McKee is one of a family of six daughters, four of whom chose nursing as their life work. She began her training at Mount Sinai Hospital. At the end of her first year there, she returned home to care for her mother for several years. She resumed her training in the Orthopedic Hospital with affiliation at the Toronto East General Hospital. She had a post-graduate course at the New York Lying-In Hospital.

Among her associates Miss McKee is noted for her quiet dignity, kindness, and efficiency. Our good wishes follow her in her release from active duty.

Historical Sketch of Medicine

A. GAUM, M.D.

MEDICAL RESEARCH has been so vast and fertile and its relations with other sciences so numerous, that the presentation, even of the principal discoveries and concepts of the time, looms as an almost impossible task. As a result, this discussion can only be superficial in nature. In the second half of the nineteenth century, and in the beginning of the twentieth, the discovery of the telephone, automobile, wireless, television, the radio, and the aeroplane have all played an

important part in influencing medicine. Patients are now brought quickly and easily across long distances to medical centres—unthought of in previous generations. It is difficult to exaggerate the effects and progress that such social changes have made on medicine.

During this period, and perhaps as the result of the new orientation of medicine, we see a great tendency to specialization. The new task of the physician, still constantly increasing, obliges him to use long and complicated laboratory studies, and requires of him special knowledge in various branches, specialized technique, skill, and the almost impossible labor of keeping up with the flood of new scientific discoveries. It has become necessary for some physicians to occupy themselves exclusively with laboratory work. On the other hand, the steady progress in all the specialties, requiring intensive study and continued practice, has necessitated that many physicians devote themselves exclusively to a single specialty.

The general physician, practising all branches of medicine, has become more rare during this period, and even those of us who indulge in general practice frequently summon the aid of specialists. However, it will be an unfortunate day when the family physician disappears from the medical horizon. No matter how the complexities of medicine develop, it would seem there would always be a prime need for the general physician as well as for specialized medical knowledge, even though an increased part of his task may be to direct the patients towards a proper specialist.

Never before has medicine penetrated to such an extent into the social life of the time. This century has seen the development of the supervision of the child, beginning on the day of his birth and continuing through his whole life. His diet is controlled, his physical and mental hygiene cared for, and his mental attitudes tested psychologically. The physician now enters the factories, controls the installation of safety devices, and gives care and treatment for industrial diseases. To this period also belongs the development of public health statistics.

In the latest conquests of human intelligence, medicine has had to map out proper regulations for the individual who is to operate in high altitudes. These bonds of medical discipline with other sciences constitute an important factor in increasing the penetration of medical knowledge. The enormous influence of the press is a further contributing factor. An-

other circumstance which has influenced medicine of modern times is the development of industry and a better organization of the working classes. This then truly is the renaissance of medicine.

In this century, biology was established on a firm basis. The study of the structure of the nucleus begun by Purkinje led to the discovery of its granules and nuclear membrane. In 1846, the word "protoplasm" was first given to the contents of the cell by the botanist, Hugo Von Mohl. These discoveries were important because they lead later to chemotherapy, beginning with Ehrlich's discovery of the various dyes and the cure for syphilis. Then followed studies on fertilization and heredity. so clearly authenticated by Mendel in his Mendelian Law. While the rapid development of biological science was bringing light to many obscure fields, physics and chemistry were also progressing in ways which had valuable results on medical thought and practice. For example, Emil Fisher's work in 1906 on the chemistry of protein, the study of carbohydrates, and the discovery of the electronsfrom this grew the important study of radio energy and radio-active substances. In 1895, Roentgen discovered the rays which lead to our modern x-ray. In 1896, Pierre and Marie Curie isolated from tons of pitchblende, a radio-active substance which was eventually to become known as radium.

Deficiency diseases had been known for some time without actual knowledge of what substances were deficient. Scurvy ravaged the sailors of Vasco de Gama and Cartier, who learned from the Indians how to cure them with the juice from the Ameda tree. Then there were the English "Lime Juicers" who introduced the fruit, lime, against scurvy. Takaki had greatly decreased the ravages of beriberi in the Japanese Navy by adding variety to the polished rice which was later shown to be deficient in vitamin B₁. It was left to Eikiman to discover that the husks of the rice contained the important substance vitamin B_r . In 1925, Holmes showed that rats deprived of vitamin A acquired night blindness and since then we have isolated practically every known vitamin and shown their

importance.

With the perfection of new staining methods and improvement in the miscroscope, histologic and cystologic knowledge were greatly extended and thus anatomy was established on a firm basis. In this era, such names as Cajal and Golgi have left their stamp on the studies of the nervous system. Then William Bowman discovered in the kidney the glomerular capsule. In this period, physiology underwent a marvellous development. The true foundation of anatomy having been made, science now turned to the study of body function in all its branches and with the aid of physics and chemistry discovery followed discovery. In the physiology of the blood, Cohnheim established the ameboid movement of the leukocytes in their passage through the blood vessels in inflammation. In 1892, when Metchnikoff discovered phagocytosis, the physiology of the circulation attained its mark.

Studies of the internal secretions have assumed high importance in recent times. The active principal of the adrenal gland, adrenalin, was discovered by Bell. Cortin, the active principal of the adrenal cortex, is a more recent discovery. In 1921, Banting and Best isolated insulin from the pancreas, which has done so much to prolong the life of diabetics. At present, work is being done on the pituitary gland, and it is felt that this also plays an important part in the diabetic process. Studies on exophthalmic goiter and myxedema have led to the discovery of Thiouracil and thyroid extract. The insignificant parathyroids were recognized in 1891 as being most important for maintaining life and that the disease of osteitis fibrosa cystica, due to excessive parathyroid secretion, could be relieved by the removal of the parathyroid tumor.

In the physiology of digestion, important work was done by Ivan Petrovich Paplov. Pathologic anatomy also came into its own in the second half of the nineteenth century, receiving an impetus from such men as Rokatinski and Virchow. Tuberculosis was first recognized in 1898 by Koch; malaria and its etiology was established by Sir Ronald Ross. Research in the histogenesis of the blood cells and the function of bone marrow gave the necessary foundation for the knowledge of pathology of blood-forming organs; thus began a new era in the pathology of the blood.

A tremendous advance has been made in microscopic technique during the past fifty years through the methods of fixation and staining. This opened new fields in the special pathology of blood, bones, and muscles. Knowledge of the anatomy of the genital organs progressed, especially in relation to lesions of the testicles and ovaries. We now recognize benign tumors as sources of bleeding. Cysts of the ovaries were made familiar by the classical operation of McDowell who removed the first ovarian tumor. The studies of malignant tumors became classified and attempts to advance with the cancer problem by experimental research are now being made throughout the world along many lines. The cause of cancer still awaits a complete answer.

Bacteriology can be credited as being the mother of prophylaxis. Thanks to the brilliant studies of Louis Pasteur, bacteriology came into its own. He differentiated between aerobic and anaerobic bacteriology. Other contributions he made to medical science were his studies on cholera, anthrax, and rabies. Then there was Klebs, who discovered the diphtheria organism, Welch who demonstrated the gas gangrene organism, and Neisser who discovered the gonococcus:

Immunization became a reality in the latter half of the nineteenth century and early half of the twentieth with the treatment of such diseases as diphtheria, typhoid fever, and whooping cough. In 1906, Wassermann gave us his important serological test for syphilis. Landsteiner discovered that human blood could be divided into four or more blood groups which has

permitted the extensive use of blood transfusions as a valuable and often a life-saving therapy. We have found that with citrates we have been able to keep blood in solution; that it can be held thus for as long as ten days, and often at the end of that time the plasma could be salvaged and used.

It is only natural, with the advent of pathology, physiology, microbiology, and bacteriology, that an improvement in the field of diagnosis should come about. Thus clinical medicine was established and with it such names as Traube who introduced Traube's Space, Leyden who studied poliomyelitis, Kussmaul who studied diabetic coma, also gastric lavage for dilatation of the stomach, which was the forerunner of the Wangensteen apparatus. Eminent among modern physicians was Nauyn, remembered for his studies of gall-stones and diseases of the liver; Curschman, for his studies on bronchial asthma, and Sir William Osler, one of the finest figures of Canadian medicine. His contributions to medicine were his valuable monographs on cancer of the stomach, abdominal tumors, and chorea.

The study and practice of surgery may have been set in motion by the various branches that we have described, but following the fundamental discoveries of anesthesia and asepsis its advance is almost comparable to jet propulsion. With the knowledge of the more secret parts of the body which can be explored without introducing infection, surgical technique has permitted difficult operations undreamed of in earlier days. clinician, surgeon, pathologist, radiologist, and various specialists not only must collaborate on all obscure cases. but must know enough of the other man's job to make the collaboration intelligent. The need for more precise diagnosis and prognosis, and indications for the proper moment for surgical intervention and subsequent treatment, have been given to us through biopsy and endoscopy which allows us to reach inaccessible body cavities, while x-ray has eliminated many doubts.

Lister's use of powerful antiseptics, with the destructive effects on the tissues, has been universally replaced by asepsis. Instruments, gowns. gloves, etc., are now sterilized by dry heat. Surgery now reaches the most delicate and remote organs, especially in the hands of specialists. Surgery of the brain, lungs, hand transplantations, and plastic surgery have made great progress during this period. Obstetrics also shared in the rapid advance of surgery; the axis-traction forceps considerably extended their field of usefulness and Cesarean sections were more successful. Knowledge of puerperal infection, transmission of syphilis to the fetus, and the cause of toxemia of pregnancy were better understood.

Startling and rapid as this progress has been, it is in no way comparable to the medical progress of the last decade. The training and teaching of nurses and internes has had to be revolutionized to keep up with these developments. It seems only a short while ago that one could walk through the wards and detect the foul smell of Patients with charcot joints, children suffering from osteomyelitis. extension apparatus applied for the correction of tuberculous hips, plaster jackets for Pott's Disease, and numerous patients recovering from mastoidectomies were common. The absence of these cases today is due to the new field of chemotherapy. With the advent of the sulfa drugs and then penicillin, post-operative abscesses have been fewer and recoveries more rapid. Because of the newer concepts of early ambulation we have had fewer post-operative accidents such as embolism, and complications such as phlebitis. Due to the pasteurization of milk there has been less bovine tuberculosis. Because of the prophylactic inoculation of children, there has been less diphtheria and whooping cough, therefore fewer complications necessitating tracheotomy. Because of sulfa drugs and penicillin, infection is controlled and, therefore, less mastoid involvements occur. the advent of penicillin, the treatment of gonorrhea has become more effective and great hopes are held for its efficiency in combatting syphilis.

Protein therapy has also come into its own, so that today we have the various amino acids which can be given intravenously to maintain the nutrition and metabolism of the patient who is unable to receive foods orally. Nourishment of the patient may be maintained in this manner for many days.

Advances in surgery have been prompted and tested during the world's greatest catastrophy—World War II. Means of combatting shock by blood and plasma have proven effective. Anesthesia has reached high levels with such drugs as Penthol Sodium, Cyclopropane and spinal anesthesia. New materials such as ligatures of nylon or cotton replace catgut; vitallium and tantalum have been used effectively for skull defects,

and for creating artificial ducts in gallbladder surgery and arterial anastomosis. Heparin and Dicoumarol have played their part in thrombosis, phlebothrombosis, and embolism, and we have learned to recognize their use at the proper time. Likewise, bronchoscopy has played its part in treating post-operative atelectasis. In fracture work, the revival of internal fixation by plates, screws, and wires is largely the result of increased use of sulfonamides and penicillin.

One could write voluminously about medicine and its numerous striking discoveries in brain surgery, gastric surgery, thoracic surgery, etc., but suffice to say that with the new electronics and atomic energies and other scientific miracles, if one could peer into the future one would marvel at the phases of medicine and surgery which have not yet been discovered.

Furacin

The yellow, glittering stuff I saw today looked like finely ground gold, but it wasn't. It was furacin. This a new, powerful drug that promises to take its place alongside the world's most effective germ killers. Its common source is plain, ordinary oat hulls — the same oat hulls which come from the great plains of the midwest.

Furacin already has established itself for effectiveness in the treatment of infected battle wounds. It is credited with saving a leg or an arm for many a soldier, who returned home with a wound that would not heal. It has proved itself a weapon against infection in skin grafting operations, in the treatment of diabetic gangrene, furuncles, surface ulcers, and infections resulting from burns. It does double duty in that it attacks both positive and negative type bacteria. In some cases, it prevents growth of infections; in others it kills. Much laboratory work to find out new secrets of furacin is now being done.

- PAUL F. ELLIS

New Wing Opened

Halifax Tuberculosis Hospital, operated by the City of Halifax, has opened a new 69-bed addition to its building, more than doubling the bed capacity of the institution. Other changes and improvements are the installation of x-ray equipment, modern operating-room, and new kitchens and staff quarters.

Under the Nova Scotia Government's

free treatment policy sufferers from tuberculosis are treated at this and other tuberculosis hospitals in the province without cost.

Halifax Tuberculosis Hospital is operated by the Halifax Department of Health and Welfare, headed by Health Commissioner, Dr. Allan R. Morton. Dr. Charles J. W. Beckwith is the hospital's medical superintendent.

STUDENT NURSES PAGE

Pott's Disease

SISTER THOMAS JOSEPH

Student Nurse

Halifax Infirmary School of Nursing, N.S.

BETTY, AGED SIXTEEN, was admitted to the ward in the forenoon of a bright September day. She was in a body cast extending from the axilla to the thigh. This plaster jacket had been applied by an interne ten days previous to her admission at another hospital. A superficial examination, while removing the patient's clothing, revealed that Betty had received good nursing care before being placed in our charge. Her teeth and hair also spoke of careful attention.

A routine urinalysis was done and the patient's history taken. The latter revealed the following:

Present complaints: Pain in upper

part of spine.

Past illnesses: Ordinary diseases —

apparent good recovery.

Present history: In May, the patient began to experience a cramp-like sensation and mild pain in the spine, between the lower borders of the scapulae. The pain became worse as time went on and walking was difficult. Sleep was disturbed and occasionally Betty awakened with quite severe The doctor was called, xrays were taken and a plaster cast applied in July. It had been changed twice previous to admission. Betty has been in bed since the application of the first cast, has had no further pain, and she now feels well, has no cough, night sweats, nor loss of weight. The diagnosis of Pott's Disease was made.

"Pott's Disease is tuberculosis of the vertebral column. The lesion is situated in the anterior part, or in the bodies of the vertebrae." According to the author "the objective in treatment is to cure without curvature, and in order to cure do not open any abscesses." To cure without curvature, he goes on to say, "make good plaster corsets. Pott's Disease may remain unobserved, but generally makes itself known by some radiation or local pains, intermitting or by functional weakness, accompanied by reflex muscular contraction, defective walking, etc."1

From the patient herself, I learned that her illness had been caused by Her foot had caught in a railroad tie and she had tripped and fallen on her face. No sign of injury was evident until a few days later when pain in her back caused great discomfort. She said nothing about this to her mother until one night she cried aloud in her sleep and on being questioned told that she had hurt her back. X-rays were taken and the last group (with the present doctor in attendance) showed almost complete destruction of the eighth dorsal vertebra on which the seventh had fused with a moderate kyphosis, or lesser curvature of the spine. This showed the disease was not

JANUARY, 1947 63

quiescent and that to arrest its progress an operation was imperative.

During the course of preoperative procedures, Betty and I became quite friendly and I learned something of her home environment. Besides her mother and father, she had an older married sister and a brother of nineteen. The latter was at present the sole support of the family. Monetary conditions were a source of anxiety. Betty's father, formerly engaged with a steel company, is now confined to a sanatorium where he is receiving treatment for pulmonary tuberculosis. Betty was quite optimistic about his recovery and did not seem aware of the poor financial standing of the One of the service clubs family. was paying all Betty's expenses and also helping to take care of the bills incurred at the sanatorium. Betty had a pleasing personality and made friends easily. This was a great asset in her long convalescence. as many of the patients who had come and gone during her illness came back to visit her.

In the afternoon of the patient's admission, the attending physician removed the body cast and placed a pillow under the affected area. The same evening the pillow was replaced by a blanket roll under the mattress. In the meantime a fracture board had been placed under the mattress. Betty did not like this but did not complain further when told the doctor wished pressure at the site of injury. The next day Betty was weighed because Avertin was to be given rectally. This was no easy task considering the length of time Betty had been confined to bed. However, with the aid of another nurse, her approximate weight was obtained. Betty was then taken to the operating-room, where, according to the report on their record, "a plaster shell was made up, with the patient suspended on a Bradford frame; some extension of lumbar spine was noted. The front was cut out of the jacket in order to remove it.'

The surgeon intended doing a bone graft and wanted the patient put in a cast immediately after the operation.

Tuberculosis of the spine may be treated

by operation in some cases, the principle of all the types of operation being to fix the spine in one position. In some types, a bone graft, usually from the tibia, may be removed from the leg and transplanted so as to unite the vertebrae. In such cases it is necessary to prepare the leg as well as the back for the operation.

Betty's back was prepared from the nape of the neck to the sacrum and her left leg from knee to toes. This was a two-day preparation with a lapse of approximately twenty-four hours between the preliminary and final

preparation.

The preliminary procedure consisted of shaving the areas to be prepared. Both areas were scrubbed for twenty minutes with a soft brush. using soap and water and changing the water three times. Sterile salt solution was used next and then, using sterile sponges saturated with alcohol, the areas were scrubbed for five minutes, washed off with ether, and allowed to dry. Sterile dressings were then applied. After a lapse of twenty-four hours, with "scrubbed hands" the areas to be prepared were again scrubbed for five minutes with a soft brush and liquid green soap, then scrubbed with alcohol and sterile sponges, washed off with ether, allowed to dry, and covered with sterile dressings. So much precaution was taken because of the danger of infection and the drastic consequences that would follow such infection.

The night previous to the operation a soap-suds enema was given. In the morning, the patient had no breakfast and morphine gr. 1/6 was given to relieve the patient's apprehension, together with atropine gr. 1/150 to diminish the secretion of mucus. This medication was given fifteen minutes before the administration of the Avertin, the latter being given rectally on the carriage.

The operation itself was long, approximately three and a half hours, and Betty was given a transfusion of glucose and saline during the procedure to lessen the shock that prolonged anesthesia entails. Twenty-five thousand units of Penicillin were also given in the operating-room with orders to give 20,000 units every three hours until 300,000 units had

been given. Penicillin was given for its bactericidal effect. Morphine gr. 1/6 was also ordered for pain

when necessary.

The operation over, Betty was placed in the cast previously made. This partial body cast enveloped the back and sides of the body but left the ventral area free. It was held in place by an abdominal binder fastened with three pins. The patient was then placed on her back in her own bed which had been taken to the operating-room.

Kept warm, with plenty of fresh air, Betty did not give evidence of great distress, apart from the usual vomiting and burning thirst. These conditions, due to the prolonged anesthesia, did not cease until forty-eight hours after her return to the ward. Starting with toast and tea, Betty was soon able to be on a gen-

eral diet.

Pressure under the axilla and around the area of the buttocks caused great discomfort. The former was relieved by having the cast "cut down" and the latter by padding the lower end of the cast with abdominal pads. These were changed after the administration of the bed-pan (slipper pan), as well as night and morn-The heel of Betty's good leg began to get tender. A "cotton doughnut" was made to relieve this discomfort. Her left leg, from which the bone had been taken, gave little trouble. The sutures were removed, the area swabbed with alcohol, and in a little over a week it was sufficiently healed for the removal of all dressings and bandages. The patient's back also healed rapidly and in due time the sutures were removed. Both incisions had healed by primary intention, without infection. the fourth week, the cast could be removed twice a week and the patient's back washed, rubbed with alcohol, and powdered with ordinary dusting powder. Formerly Neoderm had been used but, being of a coarse texture, it had caused itchiness. The patient looked forward to this treatment but was always glad nevertheless when the cast was on again.

Of a happy disposition, Betty from the start had been a favorite in the ward. She was plucky, had a sense of humor and, despite a lack of culture, had an innate refinement that charmed. Despite her sixteen years she was still much of a child. Her mother had left three days after the operation so various devices had to be thought of to keep her from getting lonesome. For awhile, Betty took delight in making paper bags. The novelty soon wore off and she tried reading. Much of the reading material that finds its way into a ward is not always suitable for a teen-age child, so certain books from the hospital library were selected to suit her taste and temperament. One in particular was a great favorite - "I was a Probationer." It kept her amused for days. Betty had decided to become a nurse and so anything that touched on the subject was of interest to her. She had Grade IX and I explained to her the necessity of completing her education if she wanted to realize this ambition. This also revived her waning interest in school and she began to make plans for studying in the summer to prepare for her re-entrance into school. She said her mother was anxious to have her continue her studies.

One day, Betty had the blues! With the doctor's permission I set to work to wash her hair. She was particular about her appearance if not exactly tidy by nature. She forgot her troubles as I dried her hair and put it up in pin-curls. All this took a great deal of time but it was well worth the effort. Smiles instead of tears were the order of the day.

Betty is now able to write letters home but cannot feed herself yet, due to her position. This is not to her liking but she found it too awkward and tiring to do otherwise. Soon she will be put into a complete body cast and taken home to complete her convalescence. All in all, this has been a very interesting case.

Calot, T. Indispensable Orthopaedics.
 2nd Ed.

Eliason, Ferguson and Farrand. Surgical Nursing.

Letters from Near and Far

The Place of the Buck Deer

Pangnirtung, Baffin Land, lies in a fiord which leads into Cumberland Sound from the northeast. Temperatures range from about 60 above, in the shade, during the summer to 50 below in winter. Growth is confined to mosses, lichens, grasses, dwarf willows flowering shrubs, with sometimes a few blueberries and mushrooms. Some of the flowers give off a lovely perfume. The so-called Arctic night descends about the middle of December and lasts till the end of January. However, the sun can be seen patting the mountain tops all winter if the weather is clear. In May, it is light at midnight and daylight is continuous during July. From Mt. Duval, which is 2,250 feet, or from the sides of the hills behind the buildings, the view is marvellous. Rocks rising 1.500 feet: jagged peaks in the distance towering to 5.000 feet: clouds caressing the mountain's cheeks, playing hide-and-seek or romping half-way down the slopes; browns and reds of vegetation in the foreground all tinted by the sun and mirrored in the mighty waters is a picture worth seeing in the summer. Winter is no less beautiful when the mountains don their royal ermine mantles and the clouds in mauve, amber, baby pink, and blue hover in attendance. The scenery combines my love of England's rugged Cornish coast and the Canadian Rockies. There is a sense of massive might creating an austere affection which I find inspiring and protective.

We have a tide ranging from twelve to twenty feet. At the head of the Sound it reaches about thirty-eight feet. The water is very deep in the fiord. In front of the settlement there is an unusual rock rampart fronting a boulder-strewn platform at low tide. The fiord extends some thirty miles inland. The settlement is about eight miles within the entrance.

There are only twenty buildings in this pioneer community, including the R.C.M.P., Hudson's Bay Company, and the Anglican Mission Hospital with a rectory which includes the church. The white population is eleven adults and three children. Eskimo of the district number 551 and are scattered at twenty-four camps. Only about twenty-five stay at the post.

The St. Luke's Mission Hospital, supported by the Church of England and by Government grants, is a long one-and-a-half storey building. The hospital was built in 1930 but is not as well equipped or furnished as the Aklavik hospital. This hospital and the Government doctor serve a huge territory, the nearest medical unit being at Chesterfield. Hudson's Bay. It can accommodate twentysix patients and two nurses on the main floor while five rooms upstairs serve for kitchen. matron's quarters, and eight indigents. Our own Delco plant generates current for electric lights, x-ray, and combination gasolineelectric ironer. No electric washer, hand-iron or sterilizers are in use here. There is an operating-room, Nuffield iron lung, sunray lamp, six wards, and one private room.

Six stoves heat the building. Three in the hall, one in the kitchen, and a 2 x 4 for the indigents are all coal-consumers while in the combination living and dining-room is a lovely oil burner. What a pleasure to handle coal after nine years of relying on wood at Aklavik and Fort George! Incidentally, coal costs \$100 per ton and gasoline \$1 per gallon here; ours is purchased "outside."

The two nurses find it most satisfactory to work days taking alternate nights on call, there being no suitable accommodation for daytime sleeping. Medications, even penicillin every three hours, can be administered with the help of the alarm clock, but when necessary nineteen and event wenty-four hours' active duty is done. There are seldom more than eight patients. This year is a record in many ways with over fifty admissions with several operations under general anesthesia.

Only a few of the hundreds of Eskimo can speak English. They are still very primitive and shy. They feel that a weekly bath with a daily morning wash is really quite sufficient for any patient. Most of our cases are malnutrition, pneumonia, tuberculosis, severe frost-bites, and minor injuries, with three tonsillectomies, six major operations, and several casts applied this year to make history. The number of mental cases is disturbing. Scabies has worked northward causing complications which have resulted in deaths where treatment was not available. In a more northerly post thirteen died. Many

of the thirty-four deaths occurring in our district, three in hospital, seem to be due to the fact that if the patient does not wish to eat, drink, or be moved he is not disturbed or crossed by the Eskimo. I sincerely hope we can soon remedy this by giving the native girls elementary home nursing, adaptable to igloo and tent life. The natives handle their own maternity cases, none coming into hospital. Many children have umbilical hernias. Babies are nursed until about four years of age.

Eskimo girls do the washing and ironing for the hospital under supervision of the kitchen matron and help with general cleaning. The three staff members do their own interior painting and spring cleaning. An Eskimo man does the chores.

There are no plumbing facilities. In summer, wash water is secured from a little creek near our building while for drinking purposes the dog-team draws barrels overland from a river about two miles away. During winter months, September to May, ice is hauled in boxes and snowblocks are cut from the snowdrifts to provide water.

Diet is a problem. The natives rely on seal, fish, and caribou. If hunting is poor and foxes scarce (none were caught last year) they have nothing with which to buy even tea and flour to tide them over. We enjoy seal, fish, caribou, rabbit, walrus, and even owl when we can get it.

All the people in the district are being inoculated against typhoid fever and diphtheria. May I tell you about some trips I had this year? October 25 found the doctor, his wife, native man, Etwana, Kunya, his boy, and me walking over snow and ice at 9 a.m. to climb into Etwana's boat (whaleboat with 5 horsepower engine) heading for the camp of Avatuktoo twenty-five miles away. We were clothed in furs, seated on a polar bear skin, and racing the elements, carrying our rations, tent, and medical supplies. About twelve noon, Etwana manoeuvred the boat around, excitedly saying it was too rough. Though the waves coming over the bow washed us, then coated us with ice, I did not realize there was anything to fear. At length we gained the shore and, sheltered by rocks, made tea with the aid of the primus stove. The pilot biscuit, crowned with a slab of Spork, tasted better than a turkey sandwich amid the intense vast solitude. We returned homeward without unnecessary delay.



Frozen foot of Eskimo boy at Pangnirtung, Baffin Land.

On January 22 the four of us set off again this time on komatiks pulled by dogs. We left at 9.30 a.m. and reached our destination about 4.30 p.m. The temperature being 50° below, it was too cold to pitch our tent. An igloo would have been warmer, but the snow was not suitable to make one so we shared one of the native's igloo-like skin tents which was covered with snow. We found some sickness. They were low on supplies and had very little seal-oil for fuel. Usually an igloo this size burnt three coodlies (seal-oil lamps) but only one tiny flame was visible. A boy with both feet frozen had been taken to the hospital a day or two earlier. There he responded weil to penicillin and casts. We crawled into our sleeping bags early, six in a row on the slightly raised platform and were up again at 6 a.m. The clothing I wore was amazing but I did not even freeze my nose despite 45-50° below. Woollen vest, two pairs of woollen pants, men's size 38 underdrawers. duck breeches, three sweaters, duffle koolata (parka), caribou koolata, caribou pants, golf



Foot of Eskimo boy after being in first cast. Note gangrene at toes.



Nearly well again

hose, caribou hip-length socks, caribou boots wool mitts, fur mitts, and beret! Natives wear two complete caribou suits.

On July 3 I had the privilege of making a short trip, without the doctor, inoculating at three camps—Avatuktoo, Ooshualoo, and Noonata. In the aforementioned boat we covered the hundred miles in twenty-four hours. Needless to say, we ate and slept while Etwana ran the boat. The poor natives

were roused whenever we arrived, even at 3 a.m.

On July 26, with Dr. and Mrs. Gaulton the singular honor was mine to be the first nurse to make a 350-mile trip calling at Bon Accord, Imegan, Ilkaloolik, Nowyapik, Iglootalik, Openlevek, Krepashau, and Kimiksoon camps. Being so close to Blacklead Island. we could not resist the temptation to go ashore and see the relics of the historic whaling station and early missionary base of Dr. Peck in 1894. We managed to complete the tour in five days. It must be the "Thousand Islands" of the eastern Arctic. Ragged, wrinkled, barren, rocky islands of every size abound. I am amazed the people are so clean for truly they are "children of the rocks" living off the country. It would add greatly to the comfort and efficiency of these visits if the Government or mission would provide a boat with a cabin. However, I am grateful for having seen some of our people in their natural environment, just another sustaining picture for those times of loneliness and doubt when we wonder if it is worthwhile or if we should have our heads read for coming North!

Mail comes via the *Nascopie* in September and sometimes by dog-team once during the winter, about March. This year a plane, parachuting the medical supplies which had missed the boat, dropped us a few letters in October. One never can tell when the planes might decide to bring us mail oftener—wishful thinking!

-MILDRED VENNING RUNDLE

Book Reviews

Aids to Tuberculosis for Nurses, by L. E. Houghton, M.D. and T. Holmes Sellors, D.M., M.Ch. 262 pages. Published by Baillière, Tindall & Cox, London, Eng. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1945. Illustrated. Price \$1.20.

Reviewed by Elsie J. Wilson, Central Tuberculosis Registry, Winnipeg, Man.

This little book, by two of Great Britain's authorities on tuberculosis, is written primarily for the nurse working in a sanatorium.

However, in these days, when few nurses know anything about tuberculosis, beyond the fact that it is a communicable disease, it could be read with profit by all.

Some of the information about the tuberculosis problem is not applicable to Canada and some of the methods are different to those in use here, but the nature of the tuberculosis problem stated in Chapter 1 is the same in Canada as in Great Britain.

Information, about tuberculosis in its various forms and degrees of activity, is

clear and concise, as are discussions on various methods of treatment. The drawings and x-ray plates reproduced in the book are clear and helpful in explaining the text.

It will be a happy day for tuberculous patients when nurses put into effect the authors' concept of what constitutes good nursing care.

Medicine in Industry, by Bernhard J. Stern, Ph.D. 209 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) \$1.50.

Reviewed by Winnifred Ruane, Industrial Nurse, Vulcan Iron Works, Winnipeg, Man. The economic, social, legal, and professional aspects of medicine in industry have been widely surveyed in this book by Dr. Stern, lecturer in sociology, Columbia University, and member of the Committee on Medicine and the Changing Order, appointed by the Council of the New York Academy of Medicine.

Dr. Stern deals with the social and legislative background, industrial disability rates, and the limited extent of preventive services. He describes the development of health insurance, the participation of trade unions in health programs, and the relation between the industrial physician and general practitioner. Particularly worthy of mention is a chapter on the handicapped worker where the author shows that, through fair preemployment examination, job analysis, and proper placement, the handicapped worker has established a good record in industry. The contents of this chapter provide enlightening data for industries lacking a fundamental rehabilitation program that is so essential today.

Although considerable advancement has been made in industrial medicine, Dr. Stern's facts and figures leave the impression that there is great need for further development in providing adequate medical care to serve the vast numbers working in industry, especially in the smaller plants.

This book does not contain material in detail to be used as a working manual but it is valuable to all those who wish to know the social aspects of medicine in industry.

Diabetic Care in Pictures, by H. Rosenthal, B.S., F. Stern, and Joseph Rosenthal, M.D.

150 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1946. 137 original illustrations (4 in color). Price \$2.25.

Reviewed by Sister M. Claire, Instructor, St. Joseph's School of Nursing, Victoria, B.C.

The authors of this book have given us a clear, attractive and long looked for, simple, but still a complete, diabetic treatment manual, which will find its place on the library shelves of all those interested in the welfare of the diabetic patient. It will be of value to the physician, the dietitian, the nurse; but its greatest value will be to the patient himself, whose safe guide it should be, for it will help him to understand his treatment and teach him how he may carry it out successfully.

This small volume contains many illustrations, all preceded or accompanied by clear explanations. The method used to impart knowledge regarding every phase of diabetic care is gradual, precise, and covers every topic needed to convince the patient of its importance. A new and practical aspect is the use of illustrations referring to food exchanges, which should be of immense value to the patient, who is so easily worried and perplexed when the necessity for substitutes arises. Moreover, these illustrations will help him adjust his diet to the family diet, and choose the right food outside the home, when required.

This book should appeal to both the patient and his family, and help make the diabetic treatment a success, for it meets the patient's needs, physical and mental, as no other manual has done before, and can justly be considered as another "precious gift" for the diabetic patient.

Physiology and Anatomy, by Esther M. Greisheimer, M.D. 841 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 5th Ed. 1945. Illustrated. Price \$3.75.

Reviewed by Mrs. Virginia Pearson of Edmonton, Alta.

The fifth edition of this well-known text presents only a few changes. Revisions have been made in the chapters on the nervous system, temperature regulation, and a very good chapter has been added on the physiology of aviation.

The introduction to the anatomy of the

nervous system begins with the functions of the nervous system in relation to the body's response to environment. The section on nerve fibres is more clearly presented and there is more detail on the divisions of the nervous system and some explanatory definitions. The order of presentation of the parts of the system is changed, introducing first the meninges, brain, divisions of the brain, spinal cord, then the cranial and spinal nerves. The distribution of spinal nerves is discussed more fully than in the previous edition. The chapter on the physiology of the nervous system has been re-arranged to correlate with the chapter on the anatomy of the system. On the whole these two sections present a more logical and clearer picture of the nervous system.

The chapter on temperature regulation has been re-arranged somewhat.

The chapter on the physiology of aviation gives a detailed account of the effects of altitude on the human body, concluding with the special duties of the nurse employed in aviation.

Alberta Department of Public Health

Helen McArthur has resigned as superintendent of public health nurses to become director of nursing services for the Canadian Red Cross Society. Jean S. Clark has replaced Miss McArthur. (See Interesting People, Nov. 1946 issue.)

Beth Laycraft has left Hines Creek for a year's leave of absence which she is spending in public health work at Chilliwack, B.C. Elizabeth Lea has left Peers and has been doing relief work. Aletha (Knudson) Glasgow after her marriage is remaining with Wainwright health district and Marie (Dufresne) Lessard is continuing at Tangent. W. Berhman has left the Sunnynook district to attend the University of British Columbia and Augusta Evans the Hilda district to take her Master's Degree at Columbia University. Mrs. Barbara Eben has been assisting in the Division of Public Health Nursing office while Miss Clark is visiting in the districts.

Appointments: Marguerite Weder, B.Sc., P.H.N., to Lindale; Katherine Brandon to Grassland, after five years, including service overseas, with the R.C.A.M.C.; Barbara Taylor to Maloy; Lillian White to Valley View.

Transfers: Frances Smith from Newbrook to Hines Creek; Ethel Jones from Foremost to take over the Peers district; Jean Blackbourne from Grassland to Foremost; Mrs. Nina Renwick from Whitemud Creek to Blueberry Mountain.

Resignations: Mrs. Edith Bennett, of Grouard, to return to England; Mrs. A. V.

Cavil from Lomond; F. M. Harrison to return to Manitoba.

Retirements: Amy Conroy from Pendryl after twenty-six years with the Department of Public Health; Olive Watherston from Lindale after twenty-five years with the Department; Blanche Emerson from Child Welfare Clinic, Edmonton, after twenty-six years with the Department. (See Interesting People, July, 1946 issue.)

Useful Hints

In the Gull Lake Union Hospital (Sask.) some useful ideas have been put into practice which might be adopted with advantage by other hospitals. The first is our method of wringing stupes. We have an ordinary clothes-wringer, fixed on a stand over one of the bath tubs in the service room. A quick turn of the handle and the stupe is dry with little loss of heat. There is no danger of getting a burn from the hot water as the waste runs down the drain in the tub.

Another useful and saving method we use here is covering our ice collars with the ordinary stockinette which is used under casts. After each tonsillectomy we can wash them and they can be used again.

- GEORGIA F. JOHNSTON

Nursing Sisters' Association of Canada

The following officers comprise the National Executive of the Nursing Sisters' Association of Canada for the coming biennium, 1946-48: Honorary presidents, Margaret Macdonald, R.R.C., LL.D.; Edith Rayside, R.R.C., C.B.E., M.Sc.; Mrs. Stuart Ramsey; president, Mary Edgecombe, World War II, Saint John, N.B.; first vice-president, Mrs. A. B. Walter, World War I, Saint John: second vice-president, Mildred Titus, World War II, Saint John; third vice-president, Mrs. C. A. Young, World War I, Ottawa; secretary-treasurer, Hazel Vallis, World War II, 64 Albert St., Saint John, N.B. Councillors, Edith Dixon, World War I. Saint John; Sara Miles, World War II, Rothesay. President, Saint John Unit, Ada Burns, World War I.

In May, nursing sisters of the Halifax Unit attended National Vesper Services at St. Mary's Cathedral and St. Andrew's Church. On November 11 a number of nursing sisters attended the Memorial Service at the Cenotaph and the wreath was placed by Sadie McIsaac, R.R.C., and J. Hubley. In the evening the annual dinner and meeting were held in the Nova Scotian Hotel with thirty sisters present. M. Haliburton, the president, welcomed the new members. Sadie Archard, R.R.C., gave an interesting report of the nursing sisters' biennial dinner and meeting held in Toronto.

Officers elected for 1947 include: President, Jean Nelson, R.R.C.; secretary, Georgina Thompson; treasurer, Lillian Fitzgerald.

A "Welcome Home" party for nursing sisters of World War II was held last May by the Hamilton Unit when twenty-one new members joined the unit. In July many members attended the biennial meeting and dinner held in Toronto. The president, Mildred Cowan, attended the executive meetings. She and the present executive have carried on for many years, the unit having few members. With new and younger nurses joining the unit it is planned to pass the reins of office on to them at the annual meeting.

A general meeting of the Montreal Unit was held in October when forty-nine members were present, including twenty-two sisters of World War II who joined the association that night. Mrs. W. Ramsay gave a detailed report of the biennial meet-

ing. On Remembrance Day the annual dinner was held when 130 members attended, including twenty-five sisters of World War II who joined the association. General Walford was the guest speaker. The president, Mrs. Stuart Ramsey, presided. It is interesting to recall the fact that she was the one who started the Nursing Sisters' Association. At the services held earlier a wreath was placed on the Cenotaph.

The fifteenth annual meeting of the Ottawa Unit was held on November 11. This was preceded by a luncheon at which sixty-eight nursing sisters were present, thirty-eight of whom were veterans of World War II. Mrs. H. J. Coghill, the president, addressed the members and extended a welcome to the nursing sisters.

A farewell tea for Blanche Anderson, who has left Ottawa, was held in September, when she was presented with a corsage. At the conclusion of the tea, the flowers and food were taken to the patients in the Veterans' Pavilion of the Civic Hospital.

On Remembrance Day a wreath was placed on the Cenotaph by Mrs. C. A. Young for the National Executive.

Officers elected for 1947 include: President, Gertrude Garvin; secretary, Maud Hill; treasurer, Gladys Clark.

The Regina Unit reports monthly social gatherings to welcome home returning nursing sisters. The Canadian Legion is planning a Memorial Hall and the unit has asked for a room in it for which they plan to be responsible. Members have acted on convoy duty — from Winnipeg to Calgary — with British brides. During the year a Florence Nightingale Service was arranged in one of the churches and nurses attended in a body. Flowers were placed in the cemetery on Decoration Day in May and a wreath of poppies at the Cenotaph on Remembrance Day.

The Saint John Unit has held three general meetings and one executive meeting during the past year. Sisters attended the National Vesper Services in May and Mary Edgecombe placed a wreath on the Cenotaph on November 11. At the annual dinner and meeting forty-seven nursing sisters were present, a large majority of whom were veterans of World War II. Greetings were received from thirty-nine absent members from

JANUARY, 1947 71

the U.S.A. and all parts of Canada. To date the unit has presented complimentary membership to 104 discharged nursing sisters. In June the new members of the unit held an enjoyable picnic when nursing sisters of World War I were their guests. Individual members of the unit contributed \$109 to the Saint John branch of the Canadian Legion, when they put on their campaign for the Memorial Building Fund.

Officers elected for 1947 include: President Ada Burns; secretary, Mrs. Earl Jamieson; treasurer, Mrs. John McCoubrey.

Several executive meetings were held by the *Vancouver Unit* and at the general meeting \$500 was voted from the War Activities Fund for the Nurses Rehabilitation Fund to be used for British nurses. A tea was held at the home of Mrs. L. W. McNutt, honoring nursing sisters of World War II. The annual picnic took the form of a delightful day-boat trip up the West Coast. The outstanding event of the year was the opening of the new T. B. pavilion at Shaughnessy Hospital as a memorial to the late Jean Matheson, beloved first matron and first president of the unit. The nursing sisters of World War I were among the special guests. A memorial from the unit will be placed in the pavilion. On Remembrance Day members attended services when a wreath was placed at the Cenotaph by the acting president, M. McCuaig. The sisters' graves in the "Field of Honor," Mountain View Cemetery, were decorated with flowers and a wreath placed at the "Shrine." Of the large number who attended the annual Remembrance Day dinner 120 were sisters of World War II.

News Notes

NEW BRUNSWICK

MONCTON:

Margaret E. Kerr, editor of *The Canadian Nurse*, was the guest speaker at a recent meeting of the Moncton Chapter, N.B.A.R.N. She gave an interesting description of the work entailed in preparing a magazine for publication. The following evening several nurses motored to "Rockaway" and enjoyed a pleasant dinner with Miss Kerr, who was the guest of honor. A book of poems by C. G. D. Roberts was later presented to her.

SAINT JOHN:

At a recent meeting of Saint John Chapter N.B.A.R.N., with Miss Down presiding, Margaret Murdoch gave an interesting report of the N.B.A.R.N. executive meeting. Dr. W. J. Fisher read an instructive paper on "Shock Therapy."

At a supper meeting of the Public Health Section, Saint John Chapter, Muriel Clark presided, with twelve members in attendance. A talk on "Art" was given by Norman Cody

after the business meeting.

General Hospital:

Fern Townsend is sending well-filled boxes to an English nurse on behalf of the alumnae association. Dr. and Mrs. George (Price) Dewar are residing in Bedeque, P.E.I., where Dr. Dewar has started a private practice.

Provincial Hospital:

Shirley Kilpatrick, Edith Wile, Bernadette

Richard, and Mrs. Irene Duplessis have joined the staff.

St. Joseph's Hospital:

At a recent well-attended meeting of St. Joseph's Hospital Alumnae Association, held in the form of a shower, many gifts were received. Two boxes were packed, one to be shipped to France and the other for a British nurse.

Mona McDermott replaces Rev. Sr. Delphine as supervisor of the central dressing room and Rev. Sr. Germaine is assistant night

supervisor.

ONTARIO

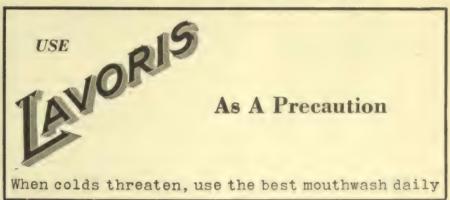
EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of new items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

CHATHAM:

A recent meeting of the Chatham Public General Hospital Alumnae Association was held at the home of Mrs. Gordon Webster, when plans were made for a forthcoming bazaar, convened by Annie Head. Jean Ross gave a report of the R.N.A.O. annual meeting. Five dollars was donated to the Little Women's Club. Miss Head, on behalf of the alumnae, presented a bouquet of roses to Priscilla Campbell, congratulating her on her appointment as president of the Ontario





Hospital Association. (See Interesting People page in this issue.) Following court whist the hostess served lunch, assisted by Jean Ross, Mmes Ray Beable and Gordon Brisby.

DISTRICT 4

At a recent well-attended meeting of Niagara Chapter, District 4, R.N.A.O., nurses from Niagara Falls, St. Catharines, Fort Erie, and Welland were present. Catharine O'Farrell, the chairman, gave a comprehensivereport of the R.N.A.O. annual meeting. Reports were also received from the general nursing, hospital and school of nursing, and public health sections. The guest speaker was Dr. L. W. C. Sturgeon, M.O.H. for Welland and district health unit, whose talk was entitled

"Public Health." He stressed the fact that the idea of health units was not new, that they were talked about fifty years ago as an aid in raising the standard of health in the community.

DISTRICT 5

At a well-attended meeting of District 5, R.N.A.O., held at Barrie, Ethel Johns was guest speaker and presented a stimulating address on "Which Way the Wind is Blowing." Claribel McCorquodale, the chairman, presided.

The annual meeting of the district will be held in the Royal York Hotel, Toronto, on February 17. Dr. Leslie R. Angus, director of psychiatric services, Devereux Schools, Devon, Penna., will be guest speaker.

Chest Rub



So gentle, Mentholatum brings quick, helpful relief to children's sore chests. Relieves congestion or money back. Jars, tubes 30c.

MENTHOLATUM Gives COMFORT Daily

THE CENTRAL REGISTRY OF GRADUATE NURSES, TORONTO

Furnish Nurses at any hour DAY or NIGHT

TELEPHONE Kingsdale 2136

Physicians' and Surgeons' Bldg., 86 Bloor Street, West, TORONTO 5. WINNIFRED GRIFFIN, Reg. N.

NURSE PLACEMENT SERVICE

Alberta Association of Registered Nurses

Qualified Registered Nurses are required for the following positions in Alberta: Superintendent of Nurses; Matrons of small hospitals; Assistant Matrons; Night Supervisors; Clinical Supervisor for Surgical Ward; O. R. Supervisors; General Duty; Private Duty; Public Health.

For further information apply to:

Margaret O. Cogswell, Director, St. Stephen's College, Edmonton, Alta.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

(Incorporated)

An examination for the title and certificate of Registered Nurse of British Columbia will be held on March 18, 19 and 20, 1947.

Names of Candidates for this examination must be in the office of the Registrar not later than February 18, 1947.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar, 1014 Vancouver Block, Vancouver, B.C.

Toronto East General & Orthopedic Hospital:

At the annual reunion dinner of the Toronto East General and Orthopedic Hospital nurses' alumnae, the Hon. Russell T. Kelley, Minister of Health for Ontario, was the guest speaker. The dinner was held in the beautiful main dining-room of the T.E.G.H. and for the majority of the nurses present it was the first time they had the pleasure of dining in the new addition to their alma mater. A choir, composed of student nurses, provided music, and J. Mathews, of Renfrew, a preliminary student, rendered two solos. Lorna Warman, alumnae president, was in the chair, and Dr. J. Ferguson, chief of staff, and Mr. J. Harris, M.P., of the board of governors, were among the speakers. The banquet was convened by Mrs. R. Taylor and Florence Kane.

DISTRICT 6

At the annual meeting of District 6, R.N.A.O., with Mrs. E. Brackenridge, the chairman, presiding, there were approximately thirty-five members present. Florence Walker, associate secretary of the R.N.A.O., addressed the meeting and brought to the district much valuable information. Sixty-five members were in attendance at the dinner and the guest speaker at the evening session was Edith Dick, of the Nurse Registration Branch, Ontario Department of Health. A. Machala, of Batawa, was elected chairman of the district for the coming year, with Sylvia Weaver, of Belleville, as secretary-treasurer.

Reports from the various sections and chapters revealed that many interesting and worthwhile activities have been carried on during the past months. The highlights of these reports are briefly summarized as

follows:

Chapter A: The graduation class of Belleville General Hospital were guests at a meeting when Mrs. Grant Sparling spoke on 'Social Service Workers." Edna Sullivan's address on "Nursing in Africa" was the highlight of one of the chapter's meetings. Donations are being received for scholarships for post-graduate work from various organizations.

Chapter C: Films on oxygen therapy and venereal disease have been shown to the graduate and student groups. The public health section revealed the organization of the Northumberland and Durham County health units. Panels on "Health Work in Industry" were conducted under the auspices of the Health League of Canada. L. Stewart was the delegate to the C.N.A. convention and presented an interesting account of the meetings.

LINDSAY:

Ross Memorial Hospital:

Aileen Flett, instructress, has resigned.

PETERBOROUGH:

Civic Hospital:

Annie L. Thomson succeeds Edith Young as director of the school of nursing. (See Interesting People, Dec. 1946 issue.) At

the last graduation exercises ten students received their diplomas and four scholarships for post-graduate courses were awarded. M. Robson and M. Langmaid have returned to the staff after post-graduate work at the University of Toronto School of Nursing. L. Pickering, head nurse in the operating-room, has received a scholarship for post-graduate study.

St. Joseph's Hospital:

The medical staff has established an annual scholarship for post-graduate study, to be awarded at the graduation exercises. I. Walsh has completed a course in obstetrics and has returned to the staff. Sr. Gonzaga is attending St. Louis University to complete her degree in nursing education.

DISTRICT 8

Ottawa General Hospital and University of Ottawa School of Nursing:

On her retirement from active nursing following twenty-one years of service as night supervisor at the Ottawa General Hospital, Isabel McElroy was entertained at dinner by the hospital staff and later at tea by the alumnae association. On both occasions

suitable presentations were made. (See Interesting People, Dec. 1946 issue.)
Sr. M. Alban has been elected president of the Ontario Catholic Hospital Association. F. Fournier is now with the Metropolitan Life Insurance Co. J. Page has been appointed to the Russell-Prescott health unit. Marie-Reine Nadon has been named field secretary of the Ontario Junior Red Cross. Anita Mercier is industrial nurse with the International Paper Co., Gatineau Mills, P.Q. K. Bayley, H. Bechard, G. Clark, B. Poulin, and A. Soulière have accepted positions with the Ottawa City Health Department.

The following nurses are taking the public health course at Ottawa University: R. Adam, I. Johnston, L. LaRocque, M. Latremouille, H. MacDonald, and R. MacIsaac.

DISTRICT 10

At a meeting of District 10, R.N.A.O., held at Port Arthur General Hospital, Wilma Ballantyne gave an interesting account of the board meeting which she attended. Miss Spidell covered a few of the important topics discussed at the C.N.A. biennial meet-

At a meeting of the Hospital and School of Nursing Section, held at the McKellar Hospital, Fort William, Dr. J. D. McIntosh lectured on "Anesthesia."

Mary Wright was responsible for the arrangements of a recent dinner meeting of the Public Health Section. Marjorie Copping gave a delightful talk, illustrated with pictures on her travels through Palestine and Indo-China. At the close of the meeting Elsie Wright, who has resigned from the Port Arthur Department of Health to be married, was presented with a gift from the the group by Violet Weston. The chairman, Bessie Jackson, presided.

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

One-Year Certificate Courses—

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses McGILL UNIVERSITY, MONTREAL 2

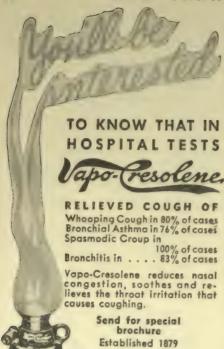
THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

THREE-MONTH POST-GRADU-ATE COURSE IN THE IMMUNO-LOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS is offered to Registered Nurses, This course is especially valuable to those contemplating public health, industrial, or tuberculosis nursing.

The course has been approved by the Registered Nurses Association of Ontario, the Director of the Department of Tuberculosis Prevention, and The Deputy Minister, D.V.A. Salary: 1st month-\$80; 2nd month-\$90; 3rd month-\$100-plus full maintenance.

For further information apply to:

Miss Ellen Ewart, Supt. of Nurses, Mountain Sanatorium. Hamilton, Ontario



LEEMING MILES CO. LTD.,

504 St.Lawrence Blvd., Montreal 1, Canada



UP-TO-THE-MINUTE DICTIONARIES

Invaluable reference books both for the nurse in training and for the practising nurse after graduation.

TABER'S CYCLOPEDIC MEDICAL DICTIONARY

By Clarence Wilbur Taber. A mine of valuable information on anatomy, physiology, bacteria, chemistry, diseases with their diagnosis, prognosis, treatment and nursing procedures; drugs, psychiatry, surgical instruments, surgical operations, pre- and postoperative care. Beautifully illustrated. 50,000 words, 1,490 pages, 273 illustrations. Third edition, 1946. Indexed \$4.00; plain \$3.50.

TABER'S DICTIONARY OF GYNECOLOGY & OBSTETRICS

By Clarence Wilbur Taber. With the collaboration of Mario A. Castallo. Illustrated. 1944 edition. \$4.00.

THE RYERSON PRESS

QUEBEC

MONTREAL:

Montreal General Hospital:

A farewell tea, attended by the medical and nursing staffs, was recently given in honor of Mabel K. Holt, former superintendent of nurses. At this time Miss Holt presented her portrait to the nurses' residence, a gift to her from the graduates of the hospital. We are pleased to welcome to our staff, Mary Mathewson, who has succeeded Miss Holt. The student nurses recently gave a tea in her honor. (See Interesting People, Nov. 1946 issue.)

Recent additions to the staff include: M. MacDonald, E. M. Sykes, M. J. McCann, P. E. Walker, K. MacIntosh, N. McKee, P. Dahms, P. Pugh, M. Hurren, W. Sproule, E. Jamieson, E. Lonergan. Mildred Brogan has handed over her duties as medical supervisor to Jean Anderson and is now classroom instructions.

instructress.

B. Hillborg and J. Goodall have retired

from the staff

Recent visitors to the hospital were: Cluny MacDonald, of San Francisco; Miss Beck-Friis, of Sweden; Rachel McConnell, and Mrs. Melinda (Franklin) Wainwright, of California.

Royal Victoria Hospital:

Mrs. Jean (Fitz-Maurice) Wigham visited the hospital recently. She has been living in England for the past seven years and expressed her appreciation to the alumnae association for food boxes that had been sent to her and other members living over there.

Kathleen Dickson has resumed her work in public health nursing in Westmount. (See Interesting People, Dec. 1946 issue.) Mrs. E. (Williams) Fleming, who has been head nurse on Ward I, has taken charge of Ross 4. J. Bulman has replaced her and Tannis Hall will be her assistant. Ruth Curtis has succeeded Betty Winch, who left to be married, in the Ross operating-room.

SASKATCHEWAN

HUMBOLDT:

Sisters Marcella and Dolores recently completed an x-ray technician course at Winnipeg. Laura Madden, of Plato, is now public health nurse for Humboldt.

MOOSE JAW:

The public health nurses of Region No. 6 have begun immunization of city and rural school and pre-school children. The immunization and infant welfare clinics, held in the regional health centre, are in full swing and it is hoped that an ante-natal clinic will soon be established. M. Edy is a new addition to the public health staff.

M. Woolliams, who was industrial nurse at Swift Canadian Co., has left to take up residence in Victoria, B.C. M. Greenwood and R. Payson have accepted positions at the

Community Hospital, Herbert.

General Hospital:

At a recent meeting of the Moose Jaw General Hospital Alumnae Association, Dr. F. Wigmore gave an interesting talk on his experiences overseas with the R.C.A.M.C. and commented on the fine work done by army nurses in the various units and field hospitals.

F. Steele is now on the staff.

Providence Hospital:

The hospital has purchased a former R.C. A.F. airport building which is being remodelled to provide a new residence for nurses. The new home will contain a reception room, canteen, demonstration and classrooms, and it will house from sixty to seventy nurses. The total bed capacity of the hospital will be increased to 200 when all nurses have moved to their new home.

Miss Straub, formerly on the nursing staff, is now with the Gull Lake Union Hospital.

REGINA:

General Hospital:

The nurses' Hallowe'en party was a great success, each class of students making a contribution to the program of skits and songs. Light refreshments were served and prizes awarded for the most original costumes.

Edna Larmour, ex-nursing sister, and recently on the staff of the Montreal Military Hospital, is now supervisor of the D.V.A. wing. I. Ficke is head nurse, male surgical ward.

SASKATOON:

An interesting film was shown to student and graduate nurses from St. Paul's and City Hospitals. The film, entitled "Poliomyelitis Clinic," was explained by Dr. H. D. Hart.

St. Paul's Hospital:

Rose Leier, a new appointment to the staff, will have charge of the health program. Hazel Arthur is on the nursery staff. Ann Beechinor and Fern Burger are taking a post-graduate course in pediatrics at the Children's Memorial Hospital, Montreal.



CASH'S Loomwoven NAMES

Permanent, easy identification. Easily sewn on, or attached with No-So Cement. From dealers or CASH'S, 37 Grier St., Belleville, Ont.

CASH'S: \$ Doz. \$1.65: 9 Doz. \$2.75; NO-SO NAMES: 6 Doz. \$2.20: 12 Doz. \$3.30; 25e per tube



When First Real Meals Upset Baby

About 75 per cent of babies are allergic to one food or another, say authorities. Which agrees and which does not can only be determined by method of trial. In case such allergic symptoms as skin rash, colic, gas, diarrhea, etc., develop, Baby's Own Tablets will be found most effective in quickly freeing baby's delicate digestive tract of irritating accumulations and wastes. These time-proven tablet triturates are gentle — warranted free from narcotics — and over 40 years of use have established their dependability for minor upsets of babyhood.

BABY'S OWN Tablets

NEW

Instructive Anatomical
CHARTS

for the training of Nurses

Edited in collaboration with prominent medical authorities

Most of the charts are printed in Canada

Please write for a free folder

RUDOLF SCHICK PUBLISHING CO. 700 Riverside Drive, New York 31, N.Y.

Positions Vacant

Nurses, with special training in Public Health, for Rural Health Units in Alberta. Salary: \$1,580 to \$2,000, depending on training and experience. Apply, stating training and experience, to Dr. A. Somerville, Dept. of Public Health, Administration Bldg., Edmonton, Alta.

Graduate Nurses for 200-bed hospital in Niagara Peninsula. Salary: \$100 per month plus full maintenance. Railway fare refunded after 6 months' service. Apply to Supt., County General Hospital, Welland, Ont.

Registered Nurses (2) for General Duty. Straight 8-hour shift; 44-hour week $-5\frac{1}{2}$ day week. Gross salary: \$126.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

General Duty Nurses for 44-bed, fully modern hospital. Salary: \$100 per month plus full maintenance. Separate nurses' home. 8-hour day and 6-day week. 3 weeks' holiday with pay after a year's service. Apply to Supt. of Nurses, Municipal Hospital, Grande Prairie, Alta.

General Staff Nurses for Nursery. 8-hour day and 6-day week, rotating on 3 periods of duty every four weeks. Apply to Director of Nursing, Women's College Hospital, Toronto 5, Ont.

Assistant Superintendent. State qualifications and salary expected. General Duty Nurses. 6-day week. Hospitalization Plan. Salary: \$100 per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

Operating-Room Nurse for Chest Surgery. Eligible for British Columbia registration. Day duty only. 8-hour day; 5½-day week. Gross salary: \$125 with increments up to 7th year. Uniforms and laundry provided. 1 month vacation each year with pay. Superannuation. Sick leave with pay, up to 2 weeks for major illness and 6 days for minor illness, accumulative. Live out. Apply, stating qualifications and experience, to Supt. of Nurses, Vancouver Unit, Division of Tuberculosis Control, 2647 Willow St., Vancouver, B.C.

Nurses for Mission hospitals in North China. 3-year term. Work done through interpreters. Write to Candidate Secretary, Woman's Missionary Society, United Church of Canada, 299 Queen St. W., Toronto 2B, Ont.

Graduate Nurses for 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to Supt., Catherine Booth Hospital, 4400 Walkley Ave., Montreal 28, P.Q.

Superintendent of Nurses for 35-bed hospital. Good accommodations and salary. Apply, stating age, experience, and references, to President, General Hospital, Digby, N.S.

Registered Nurses for General Duty. 8-hour day and 6-day week. 28 days' holiday with pay after 1 year's service. Commencing salary: \$125 gross. Dietitian also required. Apply to Supt. General Hospital, Kelowna, B.C.

Public Health Nurse for City of Galt. Salary: \$1,600. Apply to Secretary, Board of Health, Galt, Ont.

Registered Nurses for General Duty. 8-hour day. Apply to General Hospital, Parry Sound, Ont.

General Duty Nurses, Case Room Nurse, Operating-Room Nurse, and Assistant Night Supervisor for modern 220-bed hospital. 8-hour day and 6-day week. Meals and laundry provided. Apply, stating qualifications in first letter, to Supt. of Nurses, Jewish General Hospital, 3755 St. Catherine Rd., Montreal 26, P.Q.

Registered Nurses (2) for General Duty in a small General Hospital in an attractive community, 50 miles from Ottawa. Day duty: \$105 per month; night duty: \$110 per month — with full maintenance. Apply to Supt., Pontiac Community Hospital, Shawville, P.Q.

Operating-Room Nurse. Apply in person or write to Lockwood Clinic, 300 Bloor St. E., Toronto 5, Ont.

Night Supervisor, Instructress of Nurses, and Dietitian for 50-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., Payzant Memorial Hospital, Windsor, N.S.

General Duty Nurse for a 20-bed fully modern hospital. Salary: \$100 per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: \$125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Instructor in Public Health Nursing, to be responsible for the integration of the community aspects of health throughout the basic course in nursing of a University Degree course. Applicants must be qualified both academically and by experience. Preference given to nurse with degree, other things being equal. Apply, stating qualifications and experience, in care of Box 1, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Floor Duty Nurse. 6-day week. Salary: \$100 per month; full maintenance and free hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Duty Nurses. Salary: \$100 per month with full maintenance; \$105 per month with full maintenance, while on night duty, which comes one month in each 4 months. 6-day week. 3 weeks'vacation with pay annually. Apply to Supt., Lady Minto Hospital, Cochrane, Ont.

Operating-room Supervisor, Pediatric Supervisor, Nursing Arts Instructor. Fully qualified. Full maintenance provided. Apply, stating qualifications, experience, and salary expected, to Lady Supt., General Hospital, Dauphin, Man.

Assistant Supervisor and General Duty Nurses for Operating-Room at Victoria Hospital, London, Ontario. Bed capacity, 575. Good salary and Cost of Living Bonus. Post-graduate and practical experience very desirable. Apply, stating school and year of graduation, age, details of experience, references, and date of availability for service, to Supt. of Nurses.

Operating-Room Charge Nurse for 80-bed hospital. Post-graduate experience preferred. Attractive salary; till maintenance; hospitalization; sick leave; holidays with pay. Apply to Supt., Norfolk General Hospital, Simcoe, Ont.

General Duty Nurses for Norfolk General Hospital, Simcoe, Ontario. Salary: \$100 per month (including pay for O.R. call) plus maintenance. Increase at end of 6 months, \$105, and at end of 1 year, \$110. 8-hour day and 6-day week. Holidays with pay; sick leave and hospitalization. Additional \$5.00 per month paid for 3:30 shift. Apply to Supt.

Superintendent of Nurses immediately for 125-bed General Hospital (active). All graduate staff. Excellent working conditions, etc. Population, 10,000. Apply to Administrator, Kootenay Lake General Hospital, Nelson, B.C.

Assistant Night Supervisor for 150-bed General Hospital in Southern Alberta. Apply, stating experience and qualifications in first letter, to Supt. of Nurses, General Hospital, Medicine Hat, Alberta.

General Staff Nurse for Night Duty in Saskatchewan hospital. 8-hour day; 48-hour week. Starting salary: \$105 plus full maintenance. Apply, stating age, date of graduation, experience, and date available for service, in care of Box 2, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Special Radio Broadcast

The attention of nurses all over Canada is directed to a special broadcast that is to be featured on the "People Ask" program during the week of January 19. The Viscountess Alexander is to be the speaker and her topic will be "Opportunities for Girls in Nursing." This short address will be broadcast in both English and French. Nurses are urged to consult their local newspapers for the details of time and station, to listen to the broadcast themselves, and to refer all high school girls of their acquaintance to it. The need for adequate recruitment programs for student nurses is as vital today as during the years of the war.

The date: Week of January 19.

The speaker: Viscountess Alexander.

The topic: Opportunities for Girls in Nursing.

Official Directory

THE CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.O.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) 'Chairman, Committee on Institu-tional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing.

Alberta: (1) Miss B. A. Beattie, Provincial Mental Hospital, Ponoka; (2) Miss A. M. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss E. I. Stewart, Health District, High River; (4) Mrs. B. Kipp, Galt Hospital. Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 ch Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5, 1334 Beach Ave., Vancouver. Nicola St., Vancouver.

Manitoba: (1) Miss B. Seeman, Winnipeg General Hospital; (2) Mrs. H. Copeland, Misericordia Hospital, Winnipeg; (3) Miss D. Dick, 145 Montrose St., Winnipeg; (4) Miss Jean McPhail, 859 Bannatyne Ave., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospital, Saint John; (3) Miss Lois Smith, Walker Apts., York St., Fredericton; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton.

Nova Scotla: (1) Miss L. Grady, Halifax Infirmary; (2) Sr. M. Beatrice, Glace Bay; (3) Miss M. Shore, V.O.N., Halifax; (4) Miss M. Stevens, Box 345, Amherst.

Ontario: (1) Miss N. D. Fidler, School of Nursing, University of Toronto, Toronto 5; (2) Miss E. Young, Ottawa Civic Hospital; (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs., Toronto 2; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. Mary Irene, Charlottetown Hospital; (3) Miss E. Wheler, Summerside; (4) Miss M. Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25; (3) Miss A. Girard, l'Ecole d'Infirmières Hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 3533 University St., Montreal 2.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss N. Lambert, 341-12th St. W., Prince Albert; (3) Miss E. Smith, Dept. of Public Health, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q. Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans Affairs, Ottawa, Ont. Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man. Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta. Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont. Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St.,

EXECUTIVE OFFICERS

International Council of Nurses: 1819 Broadway, New York City 23, U.S.A. Executive Secretary, Miss Anna Schwarzenberg.

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall.

Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses: (Acting) Miss Margaret Cogswell, St. Stephen's College, Edmonton. Registered Nurses: (Acting) Miss Margaret Cogswell, St. Stephen's College, Edmonton. Registered Nurses: Miss Laura Fair, 214 Balmoral St., Winnipeg.

New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law. 29 Wellington Row, Saint John. Registered Nurses' Ass'n of Nova Scotia: (Acting) Miss Nancy Watson, 301 Barrington St., Halifax. Registered Nurses' Ass'n of Ontario: Miss Marida E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5. Prince Edward Island Registered Nurses Ass'n of Nova Scotia: (Miss Marida E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 1012 Medical Arts Bldg., Montreal 25. Saskatchewan Registered Nurses' Ass'n; Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

80

O VOLUME 43 NUMBER 2 MONTREAL FEBRUARY 1947

THE CANADIA NURSE



 Teaching and Learning in Schools of Nursing

by S. R. Lavcock

Electroencephalography

by H. H. and M. G. Jasper

Guilt and Anxiety
 as Social Controls

by D. E. Cameron

• Study Hour







had on duty, the Government would probably have a brand new class of capitalists to tax. Every nurse, however, realizes that it pays big dividends to obtain rapid symptomatic relief by the use of a tested and effective analgesic.

Tabloid' Brand 'Empirin' Compound is just such a preparation. Its formula has won virtually universal approval for its effective analgesic action, while the purity of its ingredients and careful compounding ensure a rapid, dependable effect. For a trial sample, simply tear out and mail the sample offer below.

Each product contains

'EMPIRIN' (Brand of Acetylsalicylic Acid) gr. 3½
PHENACETIN gr. 2½
CAFFEINE gr. ½

TABLOID BRAND TRADE MARK COMPOUND

Please send me without obligation a sample issue of 'Tabloid' Brand 'Empirin' Compound.

Name

Address





The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR FEBRUARY, 1947

Providing the Keys		99
ELECTROENCEPHALOGRAPHY	M.D. and M. G. Jasper	101
GUILT AND ANXIETY AS SOCIAL CONTROLS.	D. E. Cameron, M.D.	107
PSYCHIATRY IN THE GENERAL NURSING FIELD		111
Psychiatric Affiliation	E. G. Smith	114
Is Cancer Increasing?	P. McPherson	117
TEACHING AND LEARNING IN SCHOOLS OF NURSING	S. R. Laycock, Ph.D.	119
"Before They See the Light of Day"		123
La Lutte Anti-Tuberculeuse	S. Leblanc	127
Interesting People		130
Notes from National Office		133
Notes du Secrétariat de l'A.I.C.		138
Ward Hypodermic Tray	C. H. Crawford	142
Tetanus	J. Thomson	144
BOOK REVIEWS		147
Appointments — Transfers — Resignations		149
News Notes.		153

Subscription Rate: \$2.00 per year—\$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, \$1.50 per year; eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 11 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published ness destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.Q.



DRAX means less washing.. easier washing..at lower cost!

Imagine! One product that can do all this! Protect washable fabrics from dirt, soil and water—thus keeping them clean and fresh-looking longer...make them easier to wash—because dirt does not get ground in to the fabric, rinses quickly away.

All this means cutting down on the size and the cost of your laundry.

And all this DRAX does! DRAX, made by the makers of Johnson's Wax, is actually an invisible, inexpensive rinse that gives uniforms, bedspreads, tablecloths, curtains, the wonderful protection of wax.

They stay clean longer . . . they wash clean easier. You'll find it will pay you dividends to find out about DRAX right now!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

FEBRUARY, 1947

Reader's Guide

We have been very gratified from time to time to read in your letters the highly commendatory remarks on the articles appearing in the Journal. Even this section has come in for its share of approval. Frequently, we are asked why we do not have a specific column entitled "Letters to the Editor" or some such thing where subscribers might air their views on controversial topics. We are willing, nay eager, to start this but feel it would serve a useful purpose only when such letters raise points of argument or disagreement. To publish all of the nice things you write us would certainly look like boasting. You are invited to send questions to the Journal for which other subscribers may be able to supply the answers. You are invited to supplement the information contained in any of the articles with additional data from your own experience. You are even invited to suggest a suitable name for such a column if and when we get enough letters rolling in to make its inclusion practicable.

Here is a sample of the sort of comment we would like to have: "I am very much interested in the three articles on tuberculosis in the December issue. I heartily agree with Miss Mabel Sharpe's article on 'Should Student Nurses have Experience in Tuberculosis Sanatoria?' Later I wish to write more along this line."

—E.М.R.

We look forward to receiving E.M.R.'s contribution.

The clear explanation of the use of electroencephalography, which has been prepared by Dr. Herbert H. Jasper and Margaret Goldie Jasper, R.N., will be for many their first authoritative information on this topic. Don't let the nine-syllable word scare you away from reading this article. It is well worth your study. Dr. Jasper is on the staff of the Montreal Neurological Institute and of the Department of Neurology and Neurosurgery of McGill University.

Some of the most impelling of the social controls have had their origins in the distant past of our race. Their imposition by thoroughly well-meaning parents has often left emotional scars which only a psychiatrist

can help to remove. Two of these, guilt and anxiety, are discussed by **D. Ewen Cameron**, **M.D.** If we can learn to apply his sound advice we will be a long stride closer to acting like rational human beings. Dr. Cameron is director of the Allan Memorial Institute of Psychiatry in Montreal.

Student nurses need to become aware of the possibilities for healing the mentally ill which exist today. Mildred Nelson, who is assistant superintendent of nurses at the Provincial Mental Hospital, Ponoka, Alta., has given us a detailed study of what psychiatry should contribute to the nurse's fund of knowledge. Ella G. Smith has completed the picture by showing us how psychiatric affiliation can be worked out. Miss Smith was acting superintendent of nurses at the Ontario Hospital, Kingston, at the time she prepared her material.

It is recognized that every phase of the child health program is important but Alice G. Nicolle takes as her thesis the fact that many health programs have been initiated through the beginnings made in the care of school children. Since the average child is six when he commences school, valuable years for the correction of physical defects, for the establishment of immunities, and for the solving of behavior problems are lost. Miss Nicolle is educational supervisor with the Division of Nursing, Ontario Department of Health.

The very special attention of all instructors in our schools of nursing is directed to the suggestions regarding teaching made by the well-known educational authority, S. R. Laycock, Ph. D. Dr. Laycock's advice is so sound that its adoption in all of our schools of nursing would effect a minor revolution in student learning. Students taught by these methods would be more alive to all the situations which confront them. Dr. Laycock's suggested methods are not new to education but they will be new to many hospital instructors. Dr. Laycock is professor of educational psychology at the University of Saskatchewan.





Vitamin D Increased to 400 INT. UNITS

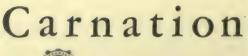
PER RECONVERTED QUART

FOR optimal growth in normal infants and children, for good bone and tooth development, and for additional protection against rickets, the vitamin D potency of Carnation Milk has been greatly increased by irradiation. Now a reconverted quart (half Carnation,

half water) supplies 400 International units as against the 162 units formerly introduced by irradiation.

The revised label shown above identifies this nutritionally improved milk, which is now nationally available.

CARNATION COMPANY, LIMITED, TORONTO

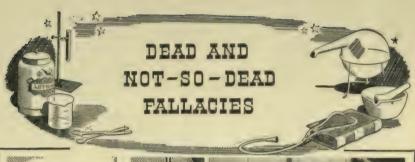






Milk

A Canadian Product







A 5TY, according to an old belief, should be treated by having it licked by a dog. When this treatment failed, the patient might try striking it nine times with a tomcat's tail, or rubbing it with a wedding ring.

STILL WIDESPREAD among people of this generation is the idea that canned foods should be cooked. This, of course, is not so—for, in the canning process, foods are thoroughly cooked. To serve, they need only be heated and seasoned to taste.



A M E R I C A N C A N C O M P A N Y
MONTREAL HAMILTON TORONTO VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

—a handy source of valuable dietary information. Please fill in and mail the attached coupon now,



AMERICAN CAN COMPANY
Medical Arts Building, Hamilton, Out.
Please send me the new Canadian
edition of "THE CANNED TOOD
REFERENCE MANUAL," which is

..

Professional Title.....

FEBRUARY, 1947

FOR THE TREATMENT OF ALL TYPES OF

Secondary Anaemia

THIRONEX"

IRON LIVER AND

Ayerst

VITAMIN B

AYERST, MCKENNA & HARRISON LIMITED

AYERST, McKENNA & HARRISON LIMITED

Biological and Pharmacoutical Chemists

MONTREAL CANADA



"Winter
taught me
about the
little
blue jar"

student nurse I learned what scores of nurses have known for years—to use the Medicated Skin Cream NOXZEMA for rough, red chapped hands, as well as unattractive skin blemishes, tired, burning feet, and other common skin discomforts.

Later I found greaseless, stainless NOXZEMA was an effective night cream, that it made my skin feel so much smoother, softer.

Now I use NOXZEMA also as a cream to help soften, whiten my rough, red hands and of course I love it as a regular base for makeup. To me, it's a "whole beauty course" in a little blue jar!..

SOLVES THE PROBLEM OF

Perspiration Odors



Used before office treatments or in the sickroom, MUM makes patients feel pleasantly fresh and clean, more relaxed.

MUM disappears immediately, and gives all-day or all-evening freedom from perspiration odors.

A dainty snow-white cream, MUM rapidly neutralizes perspiration odors without interfering with normal sweatgland activity.

There is no irritation, no injury to delicate fabrics when MUM is used.

Why not try a jar of MUM today?

Takes the odor out



of stale perspiration

Special Notice to Public Health Nurvey: Mum's Personal Grooming programme now includes "Grooming for School" charts and leaflets to aid you in your work with the younger teen-Write today for your copy

A Product of BRISTOL-MYERS COMPANY of Canada, Ltd., 3035 St. Antoine Street, Montreal 30, Canada



Keep Fit!

FOR YOUR JOB . . .
AND FOR YOUR LEISURE HOURS

with

"NEO-CHEMICAL" FOOD TONIC

In these busy days of help shortages on hospital staffs, you owe it to yourself to keep fit so you can enjoy both your work and your off-duty hours. NEO-CHEMICAL Food Tonic is the most complete vitamin and mineral food supplement now on the Canadian market. Supplement your diet with this inexpensive source of the vitamins and minerals so necessary to perfect health. Feel your best both on the job—and off!

SPECIAL OFFER TO CANADIAN NURSES

We shall be glad to send you a supply of "Neo-Chemical" Food for your own personal use. Please mention this magazine when writing.

Charles E. Frosst & Co.

Montreal

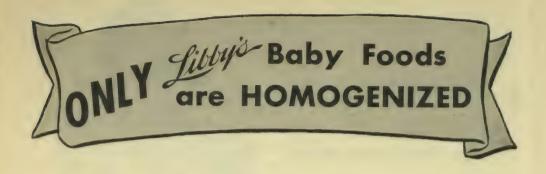
Canada



Since 1899 the Symbol of Progress
in Pharmaceutical Research









WRITE FOR DR. KILLIAN'S REPORTS ON INFANT FEEDING

A series of bulletins by Dr. Killian summarizing and discussing clinical and laboratory studies on infant feeding are available to pediatricians and physicians. For copies, write to Libby's, Chatham, Ont.

Homogenization speeds digestion of starches

When strained baby foods were compared with Libby's strained and Homogenized baby foods, experiments showed that nearly all the starch in the strained vegetables was enclosed in intact vegetable cells, and from two to four hours were required for digestion of this starch. On the other hand, no intact cells were found in Libby's Homogenized vegetables. All of the starch was extracellular and digestion was complete within one hour. These results clearly indicate that Homogenization of baby foods renders these foods easily digestible, even by the delicate digestive apparatus of a young baby -they are well tolerated as early as the sixth week. It also enhances the nutritional yield of the foods because it increases the availability of the contained nutrient. Both these conclusions have been proved during clinical tests. These obvious nutritional

advantages are true only of Libby's Baby Foods because only Libby's are Homogenized.



BFM-9-46

LIBBY, McNEILL AND LIBBY OF CANADA, LIMITED, CHATHAM, ONTARIO

94

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER TWO

MONTREAL, FEBRUARY, 1947

Providing the Keys

Books are keys to wisdom's treasure;
Books are gates to lands of pleasure;
Books are paths that upward lead;
Books are friends. Come, let us read.
—EMILIE POULSSON



Since Primitive times, mankind has sought some medium for preserving a record of events as they transpired. The Egyptians engraved inscriptions on stones, on the walls of their monuments and on columns. The Assyrians pressed their records upon tablets, which were hardened by baking. The Greeks and Romans used tablets of wood coated with wax on which letters were traced with a stylus. Two such tablets, joined together at the back with wires, are the earliest arrangement which resembles the modern book. A raised margin was left around the edge of the wooden tablets to prevent the wax from rubbing.

Papyrus furnished the first flexible material for writing, then parchment, then paper pressed from cotton or linen fibres. The first real impetus to the production of books came in the Middle Ages. Though the quality of the paper was poor by our standards, many of the books produced at this time were marvels of beauty and workmanship. Their production might take a lifetime since everything was done by hand. Few persons could read and the supply of books was sharply limited. Then, about 1450, John Gutenberg perfected his invention of printing from movable types and a new era had dawned. Books did not immediately become plentiful but gradually there were improvements in both quality and quantity. Today, that person is poor indeed who does not possess a few favored volumes.

One of the most vicious assaults

FEBRUARY, 1947

that was made by the conquering hordes of the enemy during the recent war was upon the books and libraries. Nothing was sacred—nothing was spared. Only books steeped in the brew of the current ideologies were permitted and the content of these was so dved by the contact that they were worthless as valid reference texts. Nursing libraries never had been so extensive as those with which we are familiar. With the destruction of such books as were available, our colleagues were abruptly thrust back into a literary gloom as deep as the pre-Gutenberg days of the Middle Ages. Not only are there no nursing texts today, there is no paper on which to print them, nor are there many authors equipped with the latest information on nursing developments to write the texts.

It is to fill this breach that the nurses of Canada are asked to assist. Books on nursing practice in all of the widely diverse branches, books on the medical aspects of the various diseases, medical dictionaries, nursing manuals, books—books—books. Not just a few individual volumes but hundreds of books are needed to bring guidance and assistance to our colleagues in all of the countries which were so badly disabled by the war. The need is now—not in some distant future.

With the object of honoring all of the nursing sisters who served in World War II, the Canadian Nurses' Association has given its approval to an active campaign to raise a large sum of money as expeditiously as possible for the purchase and distribution of these books. Committees are to be set up in each provincial association to co-operate with the National War Memorial Committee in raising this money. The special drive will commence this month and continue until May 1, 1947. Provincial associations have been allocated specific objectives based on an approximation of the number of nurses, graduate and student, in each province, as follows:

Alberta	i			 	 	 	. \$	2,000
British	Co	lun	ıbia	 	 	 		3,700

Manitoba	2,000
New Brunswick	900
Nova Scotia	1,600
Ontario	10,000
Prince Edward Island	200
Quebec	10,000
Saskatchewan	1,600
Total	\$32,000

In round figures, that is less than a dollar per person. If that total can be passed, it will mean just that many more books. If every nurse in Canada, active or retired, young or old, contributes one dollar as a part of a useful and active memorial, thousands of nurses in all parts of the world will benefit.

Contributions may be sent to your provincial nurses' association or directly to the Canadian Nurses' Association, 1411 Crescent St., Montreal 25. Cheques should be made payable to the War Memorial Trust Fund.

It is planned to have a special book-plate prepared to commemorate the courage, fortitude, physical and mental sufferings of those who served. This will be affixed in each volume. The assembled libraries will be sent to the nurses' associations in the various countries where they will be available on loan to all who can read English.

The question quite naturally will occur to many nurses-what good will it be to send books written in English to these foreign lands? Fortunately for the purposes of this memorial, the great majority of nurse educators in the European and Asiatic countries read English readily. Where French textbooks are available, these will be supplied to supplement the English volumes. No attempt will be made by the special committee to provide translations. This is a long, arduous, expensive, and time-consuming task. The books are needed now.

The readers of *The Canadian Nurse* are urged to acquaint their professional friends with this project. Let us all unite in raising the desired sum quickly.

—M.E.K.

Electroencephalography

HERBERT H. JASPER, M.D. and MARGARET GOLDIE JASPER, R.N.

THE SUBJECT OF THIS ARTICLE must appear forbidding and uninteresting to many of the readers of this Journal. It represents a fascinating and relatively new method for recording the electrical activity of the brain, commonly known as "brain waves." The long word used to describe this new technique is not so difficult if broken into its three parts: electro — encephalo — graphy. It was derived from the Greek elektron relating to electric, enkephalon meaning the brain, and graphein meaning to write. It may be defined simply as a graphic record of the electrical activity of the brain.

The word was first introduced by a German scientist and psychiatrist, Dr. Hans Berger, the man chiefly responsible for the establishment of this technique. He first called the records of the electrical activity of the brain "elektrenkephalograms." This was translated by English scientists into the hyphenated word "electroencephalograms," and later the hyphen was dropped by American authors giving us the present "electroencephalogram" or E.E.G. for the records themselves, and "electroencephalography" for the complete technique of studying brain function by means of its electrical "brain waves. A specialist trained to take and to interpret the E.E.G. is known as an "electroencephalographer." There is now an association of such people called the "Eastern Association of Electroencephalographers."

The late Dr. Hans Berger, who was director of the Neuropsychiatric Institute and professor of psychiatry at the University of Jena, Germany, published his first paper describing the E.E.G. in 1929. This was followed by a series of papers in the *Archives für Psychiatrie* describing how an accurate record of the electrical activity of the human brain could be obtained through the intact skull and scalp.

The principal features of the normal E.E.G. were established and various forms of abnormal waves associated with brain lesions and diseases were described. Berger received little recognition in his own country until the great English physiologist, Professor Adrian. and his colleague, Dr. Matthews, confirmed the fundamental observations of Berger and drew the attention of the scientific world to the importance of his discovery. Investigations were soon begun at Boston and Providence in the United States where the first clinical E.E.G. laboratories on this continent were established in 1935-36. Ten years later we find that electroencephalography has become an established technique of importance for the study of diseases of the brain comparable to electrocardiography for the study of diseases of the heart.

TECHNIQUE

Electrical activity of the brain is now usually recorded by means of electrodes attached to the scalp surface with collodion. Berger originally used needle electrodes inserted through the scalp to the skull, but it has been found that brain waves can be faith-



Method of attaching electrodes for electroencephalography. Small silver discs connected to a wire are attached on the head with collodion. Drying the collodion with a hair dryer is shown in this illustration.



Patient placed in electrically-shielded quiet room with electrode wires placed in the plugboard ready for recording.

fully recorded without penetrating the scalp. When the brain is exposed during an operation they are recorded directly from the brain surface with small cotton covered electrodes held in a special holder attached to the edge of the skull opening. The scalp surface electrodes are small silver discs about 1 cm. in diameter, shaped like a small hat with a hole in the top. After they are attached to the scalp, an electrolytic jelly is inserted through this hole with a syringe so that a good



The electroencephalographic recording apparatus, which is placed outside the patient's room.

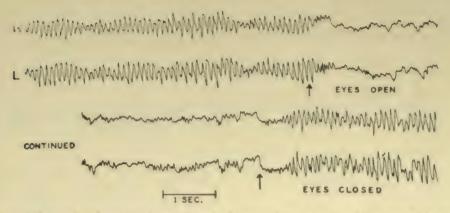
electrical contact is made between the scalp and the electrode.

Fourteen to sixteen such electrodes are attached to the scalp for a complete examination from various brain areas beneath. The position of these electrodes is carefully measured so that they will be over approximately the same areas of the cortex in each patient. Electrodes are also placed on the ears for records from the under surface of the temporal lobes, and occasionally an electrode is placed through the nose on the posterior nasopharynx (the "basal lead") to obtain electrical activity from the base of the brain.

When the electrodes are all attached and the contacts assured, the patient is placed in a quiet, electrically-shielded room where all the wires from the electrodes are plugged into a board something like that used by telephone operators. The electrically-shielded room helps to eliminate electrical interference from elevators, x-ray, diathermy, and other sources which might be picked up by the extremely sensitive apparatus used to record the E.E.G.

Outside the room for the patient is placed the E.E.G. apparatus in front of a large viewing window where the operator may watch the patient while the records are being taken. The wires from the head are lead into a selector switch-box for connecting the apparatus to various combinations of electrodes. The minute electrical waves from the head are then amplified over one million times by especially designed vacuum tube amplifiers something like those used in radio. Four or six channels of recording apparatus are used simultaneously.

Brain waves are measured only in millionths of a volt (microvolts) so that extremely sensitive apparatus is required to amplify them sufficiently to make them activate fast moving pens on the recording paper. Consequently, the patient must rest very quietly for, when he moves, or even when the nurse moves about in the room with him, disturbances may be introduced into the E.E.G. record known as artifacts. Relaxation of



Sample of normal alpha rhythm from right and left occipital lobes as affected by opening the eyes

mind as well as of body is necessary for a good E.E.G. record. This is one of the important jobs done by the E.E.G. nurse-technician. There is no pain, discomfort, or danger.

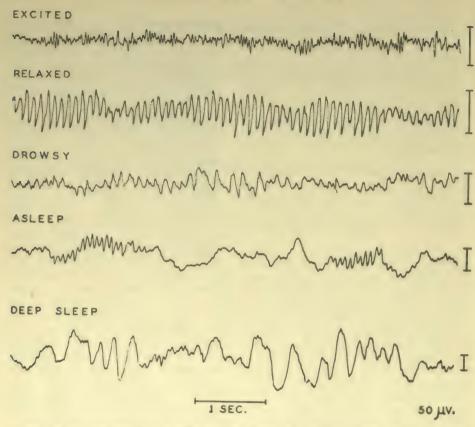
No electrical current is passed through the head. The records are made up of the electricity generated by the brain itself. Many patients, however, are naturally apprehensive about anything that has to do with wires and electricity, so that some assurance may be required before a satisfactory examination may be obtained. This is especially true with young children and in patients with certain forms of nervous or mental disease.

NORMAL ELECTROENCEPHALOGRAMS

In spite of the enormous complexity of the human brain its electrical activity appears to be quite simple. There is a dominant 10 per second rhythm of regular waves, most prominent from occipital regions, known as "alpha rhythm." (These waves were once called the "Berger Rhythm," but this terminology was discouraged by Berger himself who first called them "alpha wellen.") Of lesser prominence, and most clearly seen over sensory motor areas of the brain, are the "beta waves," less regular oscillations tend at about 20 to 30 cycles per second. Occasional waves of lower frequency are seen in the records from certain normal individuals, but the

alpha and beta rhythms are the principal features of the electroencephalogram from normal people, relaxed with the eyes closed. Opening the eyes, and emotional or nervous tensions, tend to cause the alpha waves to disappear so that they are maximal when the patient is relaxed with the eyes closed. Too much relaxation also results in their disappearance, to be replaced by slower waves characteristic of drowsiness or sleep. There is a sort of basal condition of alert relaxation with the eyes closed which must be Obtained in a patient in order to have an optimal E.E.G. recording.

Brain wave patterns and frequencies are very constant in a given individual from day to day if these basal conditions are maintained. There are wide differences, however, from one individual to another. An individual may be characterized by his brain wave patterns in a manner analogous to his finger-prints. This seems to be an hereditary trait since identical twinshave almost identical E.E.G. patterns, although one pair of twins may show a very different pattern from another pair. This applies to certain abnormal brain waves as well as normal patterns, as will be pointed out later with reference to the epilepsies. It is presumed that these individual differences in brain wave patterns may have some relation to certain personality characteristics, but no such relationship has yet been clearly demonstrated.



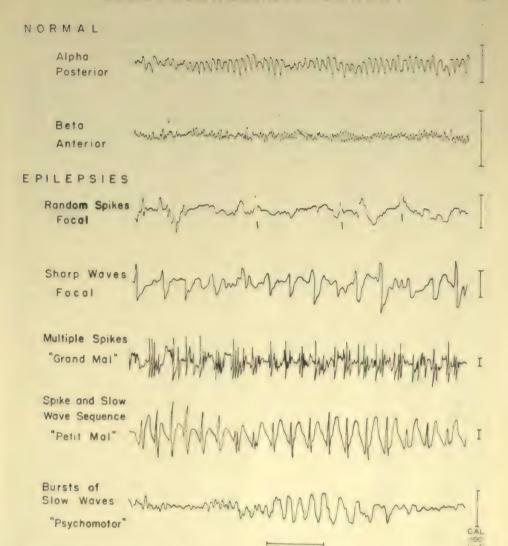
Sample electroencephalograms from a normal subject showing the effects of excitement, drowsimss, and sleep.

ABNORMAL ELECTROENCEPHALOGRAMS

Most abnormal conditions of the brain which tend to depress its function, such as is seen grossly with a patient in coma, produce slow waves in the E.E.G. These slow waves, or delta waves, may range in frequency from 6 or 7 per second to less than 1 per second depending upon the severity of depression of brain activity. It is only in the most extreme stages of brain injury or disease that the brain waves actually disappear. Diseases which are associated with abnormal states of excitation within the brain, such as epilepsy and certain toxic conditions, are often associated with fast brain waves or "spikes." Hence the E.E.G. may be abnormal when the waves are too slow or too fast. This has been called cerebral dysrhythmia. Amplitude, regularity,

and form of the waves are also of importance. Bursts of high voltage waves (called "paroxysmal") of most any form or frequency may indicate a tendency to brain disorder similar to that seen in patients with epilepsy. The particular form of the waves, and their localization, may indicate the origin and nature of the epilepsy.

The epilepsies may be divided into three major groups according to their electroencephalograms. There are first those showing a well-localized spike or sharp wave focus which usually indicates that part of the brain from which the seizures begin; this being often in the vicinity of a local brain injury or tumor. Another group of patients will show bursts of high voltage rhythmic waves often at frequencies of 3 or 6 per second with special patterns such as the "wave and spike" or "dart and dome"



Normal alpha and beta waves shown above as compared with various forms of abnormal discharges from epileptic patients.

forms. These waves appear simultaneously and synchronously from homologous areas of the two hemispheres. They probably arise from some sub-cortical source or pacemaker. It is in this group that we find most of the patients with so-called idiopathic epilepsy and those children with *petit mal* attacks and some with *grand mal* attacks as well. Patients with epileptoid behavior disorders or automatisms also frequently show bilaterally synchronous E.E.G. disturbances.

There is a third group of epileptic patients who show disorganized diffuse disturbances from all parts of the head, some fast and some slow, with a tendency for high voltage waves to appear periodically. These are known as the diffuse disorders and usually indicate a generalized rather than a local disease of the brain which is causing the epileptic seizures. Certain of these patients are also called "idiopathic" or "cryptogenic," meaning simply that the cause of their disease is unknown, or at least poorly understood.

By memeral the left Cent backage found by Dre Lonnor and Cabbe that there is a strong bereditary factor in cortain forms of idiopathic children, cince examination of the parents and enlatives of patients with this form of apilepsy revealed many with L. L. C. denormalities of the same form as those found in the patients the marlyrs, though the almornialities were usually has severy. It is the patients with the bilaterally symphronous disorders, especially of the Aper account or wave and spike type, which are most likely to have a strong hereditary background. There has been me evidence that patients with local chilepay, due to heat brain inputs, have a significant herelitary basis for their discase. The L.f. C. has been of considerable aid, therefore, in the differential diagnosis of the epilepsies.

In patients with a jource or spells of a type not certainly related to the epilepsies, the cliebroeicephalogram can often give a certain diagnosis, but not always. When it is definitely positive the diagnosis is quite certain, but when the L.L.C. is negative of questionable, the patient may still have epilepsy. Almost 10 per cent of patients with known clinical epilepay have been found to have normal or hurderline electros neephalograms. This might be expected in a discuswho has variable and pariodic, so that at times between sciences the b. E.C. may appear quite normal.

In progressive destructive lesions of the brain, such as tunners in van rular lesions, the site of the lesion may be by aligned by the late to the miner often hy a foreign of delta (alow) waves. Or casionally, the circuit the leasn is revioled only by asymmetries in amplitink or frequency of the ways from the two advant the heat. Leaons ly ing thep within the brain are more difficult to localize. It a part of the begin has been removed, leaving me abnormal risms behind the b. b. C. may return to normal even though the principal may show marked paralysis or less of mental function the to the less of brain substance. Diagnosis of the particles of the leasn cannon be much by the 1 1 to since lessons due to trainna, tumor, hemorchage, or thrombosis may produce similar E.I. C. abnormalities

Curiously, there are quite a number of people walking about among us, presumably "normal" individuals, who do not have what are considered stretts normal electrocic oplialograms. 'anne of these individuals have latent brain disorders of an heroditary charactor as, for example, in the parents of patients with diopathic chilepsy There are others who have suffered a head injury (at birth or after) with apparent complete recovery and others who have probably had some form of encephalitis with apparent complate clinical recovery. Because these individuals are able to make a satisfactory personal and social adjustment to life they are considered "normal" even though the sensitive eye of the U.L.C. is able to detect residual disturbances in their brain waves There are undoubtedly more individuals among the so-called "normal" population who are making adjustments to minor abnormalities of brain function than can be detected by the electroencephalogram.

As a matter of fact the L.E.G. is a very coarse and crude index of brain function. The simple waves observed can have only a very limited value in the altimate analysis of the complexities of rerebral activity. This is emphasized by the lack of significant changes in the L.E.G. in many of the most severe mental discuss and also by the fact that brain waves from a guinea pig or a water beetle may show a striking resemblance to those obtained from the human brain.

In conclusion it should be added that the electroencephalogram is a valuable aid in the diagnosis of epulepsy and cortain other brain besions and discusses, but that it is not a substitute for an accurate history, careful asture observation of the patient, and guist china at judgment. It is only in the light of these that the E.E. Consists of the sately used in conjunction with other talonates and in conjunctions with other talonates and in engineers with near and it are atment of patients with nervous and mental discuss.

Guilt and Anxiety as Social Controls

D. EWEN CAMERON, M.D.

Before coming to grips with these topics, it is necessary to clear the ground—and clear our minds. For our predecessors made great use of anxiety and guilt in their thinking about human behavior. They used them to an exceptional degree as a driving force to turn the wheels of their social structure. They worked out ideas and beliefs about anxiety and guilt which were useful enough in their lives but which are now out of date and are muddling our thinking.

Each new group, as it takes over the scene from its predecessors — the Victorians, the Edwardians, those who lived through the first World War — has had this selfsame job of clearing away the wornout concepts, the used-up beliefs and the antiquated ideas left behind by those who occupied this uneasy earth before them.

When we come to consider this matter of the use of guilt and anxiety as social controls, the amount of clearing away that is necessary is quite prodigious because of the very fact mentioned above, namely, that those who went before us made such great use of them.

Let us start off by saying that social control is an essential of our survival. If we are to live together, then our actions — the actions of ourselves and of our neighbors — must be subject to control. For we are by nature expansionists, and aggressive expansionists at that. We seek continually to expand our mastery over our world over the weather by building houses, over time and distance through the rapid development of our transportation systems, over our fellows in the endless rivalries and competition of the family, the office, and, in bloodier form, between national groups.

Fortunately we arrive in this rather difficult world with certain devices already built into our natures which greatly facilitate our capacity to establish social control. These devices are the capacity to feel pain, to feel anxiety, and to feel guilt.

The use of pain as a social control I shall dismiss briefly by saying that it is much less used than it was. True enough, the sound of the parental slipper is still heard at the bedtime hour, but not so much as formerly. The ecclesiastical rack and the torture chamber, once used to wrench the sinner back to the path of righteousness, have disappeared save for a brief and horrible revival under the Nazis.

We still use, and probably shall continue to use, anxiety and guilt for quite some time as social controls. We are using them, however, differently from the way in which our grandparents and great-grandparents wielded them. It is most important to define these differences since, oddly enough, although we use them differently there is still a hangover of our old ways of thinking about them.

At this point let me make some statements which our predecessors would not have made but which nonetheless are gaining increasing acceptance in our days.

The first statement is that ideas of right and wrong are not inborn. During the last several decades a flood of information has come to us from other cultures all around the world information concerning the very different ways in which such matters as the bringing up of children, the dividing of property, the managing of marriage, and the administration of justice can be carried out. There was a time when we were prone to dismiss these as the ways of natives, savages, or simply foreigners. Now we recognize them the different ways in which human beings have been able to work out their relationships with each other and have been able to solve some of the profoundly difficult problems of living together. We can see very clearly that in their various settings these quite different ways of managing things operate fairly satisfactorily. They work well even though they may not be acceptable in our own culture, though they may be designated as "bad." Similarly, those things which are accepted in our culture are often considered "bad," "wrong," "not done," in others. For instance, the simple custom of eating in public is regarded as a matter of embarrassment and shame in Bali.

In a word, "good" and "bad" are relative, not absolute things. great difference between the way in which those who lived before us thought about anxiety and guilt and the way in which we think about them is thrust into still sharper outline by the statement that they looked upon the excessively conscientious person, the person prone to feel guilty over every passing trifle, as someone who had a specially delicate sense of right and wrong and who for that reason was to be considered a specially worthy person. We, however, think of him as having a limited and crippled personality and as having been damaged most probably by unhealthy childhood experiences. Similarly, anxious-minded people we now know to be very rarely those people who are taking unnecessary risks and are more often people whose sense of security has been badly shaken by exposure to insecure people during their earlier years.

We are born with the capacity to feel anxiety and guilt. We are not born feeling guilty about anything. The things to which we may respond with feelings of guilt when we are twenty are things which we have been taught, during the intervening years. to feel guilty about. The same is very largely true about anxiety. When we are born we have a capacity to respond by anxiety, but there are only a few things, such as loud noises and the fear of falling, which seem to be inborn. All other fears and anxieties are acquired through the experiences we encounter in living. We have now come to the point where we recognize that we ourselves decide what things we are going to feel guilty or anxious about, and also how guilty and how anxious we are going to feel about those things. This represents a very radical departure from the thinking of our predecessors, who felt that these things were inborn, that they were part of the nature which man had been given, and that for this reason we should not attempt to do anything about them.

Now, having contrasted the old and the new ways of looking at anxiety and guilt, let us say that we still need these two things as social controls, though they are crude and clumsy. The essential difference is that from here on we are going to attempt to use them rather than think of them as being something preordained.

Perhaps we can see something of what we are likely to do in the future about anxiety and guilt if we look at what we have already done about pain. We have not tried to abolish the capacity of individuals to feel pain. To do so would be very hazardous indeed since we might suffer a great deal of damage if we were not capable of knowing that the cigarette was burning our fingers or that something was going wrong with our appendix. But we have tried to eliminate the causes of pain and we have tried to prevent pain from going on unnecessarily. As soon as it has drawn our attention to the fact that something is wrong, we try, through aspirin, codeine, or the general anesthetics, to protect the individual against too much suffering. Interestingly enough, this last step, though now so widely accepted, was not achieved without something of a struggle. Shortly after the general anesthetics were introduced, their use in childbirth was proposed. For a time this was stoutly resisted, on the grounds that it was "natural" for a woman to suffer pain at such times, and to interfere with it was to interfere with the ways of Providence. Fortunately this ancient idea has been forced into the retreat into which all such dogmata are being driven.

Now, if we look at anxiety, we will

see that we are already beginning to try to identify the causes of anxiety the dangerously insecure people who as parents transmit their anxieties to their children through the unhealthy atmosphere which they create, the anxiety produced by the high-speed industrial job, by economic insecurity. Many of the old anxiety-producing ways of looking at things are disappearing. We no longer try to control our children by telling them ghost stories, we no longer talk about the "unforgivable," the "uncorrectable." The nineteenth century woman who was "irretrievably ruined," and the Kiplingesque character who was "beyond the pale" live now primarily in fiction.

It may be that we can eventually accomplish something of the same thing with guilt that we have done and are trying to do with respect to pain and anxiety. Our first step must be to recognize that although for a time we shall have to continue to use guilt and anxiety as ways of controlling ourselves and our neighbors, a great deal of damage is done by the ignorant manipulation of the anxiety and guilt feelings of people. To this one must add that some damage is not done in ignorance but is done through the deliberate fingering and manipulating of other people's feelings of guilt and anxiety for the profit of individuals and institutions.

Here is the kind of damage that can be done in ignorance by a mother who is herself prone to react to living by excessive guilt and excessive anx-A twenty-four-year-old girl comes to the psychiatrist saving that she feels inadequate, in the office, with her friends and, indeed, everywhere she goes. In particular she feels that she cannot make friends with boys. she is afraid of them. She has nothing to say when her girl friends begin to talk about dates and dances. We get a history, which she brings out with the utmost reluctance and with the strongest possible resistance, that from the age of four to eleven she had sexual adventures with a number of little boys. She went through these

with apparently no more guilt feelings than she would have suffered in stealing cookies. At the age of eleven she told her mother what had happened. The latter responded explosively, with denunciations and, for a time, with complete rejection of the girl. She told her that what she had done had ruined her, that no one would ever have anything but contempt and loathing for her. She said that she could never trust her daughter again out of her sight, that the girl had no idea what men were like. From that time on, not unnaturally, the girl developed those fears and feelings of guilt in the presence of boys which now, at twenty-four, have entirely obliterated her capacity to enter into any friendships of even the most limited kind with men. Here, then, is the feeling of guilt and anxiety used as a means of social control to an excessive and extremely damaging extent.

Then again we find the feeling of guilt used by a mother who was deeply insecure herself and whose relations with others were pervaded by hostility. From the earliest years of her daughter's life this mother used criticism and the withholding of affection as a means of controlling the girl. To these the mother added the fostering of the girl's sense of guilt. The method is age-old and very well known. Whenever the child showed any tendency to rebel against her mother's continuous criticisms, the latter would respond by saying, "You don't appreciate what I am trying to do for you. I work day and night until I am so tired that I could drop. But you have none of the love that a daughter should have for her mother. You are an unnatural child." This was carried on to its logical conclusion where the mother told the little girl that her continual naughtiness was causing her mother so much worry that her heart was becoming affected and that she might die. When by chance the mother did fall sick from an attack of pneumonia, she used the occasion to say to the girl, "Look what you have done to me.

These things to the adult may look pretty small; they may seem things

that one could brush away pretty easily. But to the child whose mother and father are truly the vardsticks of his existence, they are tremendously important. The removal of the father or mother by death looms as a major catastrophe, and attitudes thus graven into the child are extremely hard to eradicate with the passing years. Consequently, when this girl reached her thirties, she still felt almost completely under the influence of her mother. She hardly dared feel hostility towards her mother's criticisms. because of the feelings of guilt which the latter had built up in her.

Eventually she came under treatment and very slowly began to recover. As her recovery became apparent her mother, however, felt increasingly threatened by the girl's emerging independence. Her critical attacks on her daughter increased and ultimately culminated in the vituperative cry, "You don't love me at all; you are only interested in my pocketbook." This was given spurious substance by the fact that the girl was so crippled by her guilt and anxiety feelings that she was unable to work and, therefore, had to depend upon her mother for financial support. Eventually the mother succeeded in her attacks and forced her daughter to break off treatment.

These are glimpses into the lives of real persons. It is easier for us to understand these great forces of anxiety and guilt in terms of people, but there is a time also to emphasize the universal nature and the tremendous potency of these forces. To realize this, and to realize at the same time to what extent our ideas about them are changing, is to realize that we are in the midst of a vast revolution of thought.

Save for a very few, it was generally

believed up until the middle of the nineteenth century that man's social institutions, his systems of belief. were not really his own — they had been given to him, or, at any rate, they were there and he had to make the best use possible of them. If he could not make them work, that was his fault, it was a sign of some inherent weakness, of inborn sinfulness. Now all this is changing. We are beginning to recognize that our social institutions, our systems of belief, are our own inventions. If we invented them once then we can certainly invent and build up better ones. Most certainly a glance around the world would make us pretty sure that most of them could be improved.

In particular we have to be especially critical of those systems of belief, those social institutions, which make excessive use of anxiety and guilt to control people. In these decades when extremely difficult decisions have to be made we cannot afford to have our children growing up with minds blocked off by guilt feelings, growing up to be people who say, "You must not talk about such things," "That's not something which can be discussed." We cannot afford to have our children coming to adult vears so anxious-minded that they cannot decide for themselves but must have others make their decisions for them. That is the road to totalitarianism, whether the system of belief on which you must depend belongs to the Right or to the Left. The Right and the Left do not really represent choices; they are the same thing. The choice is between them and freedom - freedom from unnecessary anxieties and guilts, freedom from taboos and useless prohibitions, freedom from all kinds of crippling social institutions.

Preview

We have heard of so many seeming miracles wrought by the use of penicillin. What effect does it have on syphilis? The latest word on the treatment of this disease will be featured next month under the authorship of Dr. B. D. B. Layton who is chief of the Division of Venereal Disease Control in the Department of National Health and Welfare.

Psychiatry in the General Nursing Field

MILDRED NELSON

T THE CLOSE of the year 1943* A there were in Canada 59 institutions for the care of the mentally ill with a total of 46,631 patients, an increase of 1.4 per cent over the previous year. For a ten-year period the increase had been gradual and consistent with no decrease at any time. The cost per capita was \$407 per year, making a grand total of \$19,199,206. This represents the cost to the state for the care of the patients who are actually mentally ill. But, besides this, if we consider the loss to the patient in salary, the cost to the state in caring for the dependents of those mentally ill, and then add to this the cost of caring for those who are still able to carry on in the community but who are not self-sustaining we would have to multiply the cost many times.

Other interesting figures have been worked out, such as, that the patients in hospitals for the mentally ill are more numerous than for all other types of hospitals combined; the number of mentally disordered individuals closely approximates the number of persons in colleges and universities. Other statistics show that one child in each group of twenty boys and girls now fifteen years of age will be sent at some time during his life to a hospital for mental diseases to spend an average of over seven years there. At the age of fifteen, the chance that such illness will develop later in life is one in twenty.

Besides the large number of patients in mental hospitals, we have in the school, in the clinic, in the doctor's office, in the general hospital, and in the community, problems of great psychiatric significance although this may not be apparent to the casual observer. The field of nursing has expanded—it is no longer merely bedside nursing in a general hospital ward or private duty in the hospital or home. Nursing today is a com-

munity service, and the functions of the nurse may be summarized and briefly stated:

- 1. Care of the sick: Care of the sick in the modern sense means care of the individual—care of a total personality—not the care of physical illness alone.
- Prevention of disease: This includes prevention of both physical and mental illness —the practice of preventive medicine.
- 3. Health education: This is the most recently added function of the nurse and the one that is receiving considerable attention and stress at the present time.

In retrospect we can see that great strides have been made in the care of the mentally ill. We read of patients formerly being lodged in dungeons, chained, beaten, starved, and even exhibited like wild beasts for the entertainment of the public upon payment of an admission fee. The publication of the book by Clifford C. Beers, "A Mind that Found Itself." aroused much interest and provided considerable stimulus for the advancement of this work. To this book and the interest aroused we attribute the origin of the Mental Hygiene Movement, started in 1907. This movement was originally started to ameliorate conditions in asylums—as mental hospitals were then called—and to prevent development of mental illness in adults. From this beginning, interest was redirected and attention turned to juvenile delinquency, behavior problems of school children and, more recently, to preschool children, stress being placed on activity and adjustment.

Hygiene may be expressed simply as the science of keeping well. Until the dawn of the present century keeping well meant keeping physically well. Today when we speak of keeping well we include both mental and physical health. The trend has been from curative to preventive medical science. With mental illness the recent trend has been to a preventive

FEBRUARY, 1947

^{*} Dominion Bureau of Statistics, 1943.

science known as "Mental Hygiene" which may appropriately be called the latest development in medicine. Muse has said that "Mental hygiene may be thought of as the psychological branch of preventive medicine, and no phase of the art of healing can afford to neglect it."

Because of the interest shown in those committed to institutions for the care of the mentally ill, some have the misconception that mental hygiene is concerned only with the more serious disorders. This is not the case. The practice of mental hygiene may be divided into two parts:

- 1. Positive guidance of the ordinary co 1 rse of life so as to promote desirable traits of personality and to avoid causing maladjustment. Each person has an effect on those about him—it may be favorable or unfavorable but it affects his adjustment. The practice of positive and constructive mental hygiene is not limited to any one professional group but is a common social duty.
- The other concept of mental hygiene is the study and treatment of those already maladjusted, that is psychiatry.

It can readily be seen that mental hygiene has a very broad field. L. D. Shaffer says, "The practice of mental hygiene is not limited to the work of the clinics or the treatment of the maladjusted. In a very real sense, everyone is engaged in mental hygiene whether he intends it or not. Preventive action in mental hygiene is of more fundamental importance than is remedial to repair damages already done. If all persons who deal with others, especially parents, teachers, and employers, governed their influence by principles of mental hygiene, there would be fewer lame and deficient personalities for clinicians to treat. The constructive measures that are applied to create effective personality have been termed positive mental hygiene." To reiterate, "Everyone is engaged in mental hygiene whether he intends it or not." The layman does not treat physical illness but must know how to recognize early symptoms and seek expert advice. In mental illness, the importance of early recognition and early treatment cannot be too highly stressed.

In considering the universal application of mental hygiene-"Every member of society has a responsibility for the promotion of good mental hygiene." From the very nature of education, the school assists the child in his adjustment to society, but his adjustment must be flexible and progressive. The child must not only make a temporary adjustment but must acquire the ability for readjustment. From the standpoint of society. the schools in a democratic state such as Canada hope to develop citizens able to play their part in a democratic state, and to make new adjustments in a changing and progressive social order, so that social stability may be united with social progress. From the point of view of the individual the schools exist to aid him in his own growth, in making adjustments to his environment which is both a social and physical environment, resulting in the development of an integrated personality, socially efficient, capable of further growth and development, capable of critical thinking, of openmindedness and freedom from prejudice, unimpeded by unregulated emotion. Education is continuous throughout life; it means progressive change for progressive living. It is the task of the school to make things intelligible by presenting principles of science in a simplified setting. Subject matter is not educative in and of itself, but only as it is made meaningful to the pupil.

Health, including mental and physical health, is the first objective of education. The pupil should achieve health by living a healthful life and by building up a sound system of health habits. These habits should be strengthened by growing knowledge and developing attitudes and ideals. The outcome of the study of health may, therefore, be classified as health knowledge, health habits, health attitudes, and health ideals.

In recent years mental hygiene has come to permeate our whole educational system and it has a place in every curriculum. The purposes of mental hygiene as expressed for Grades I and II are:

- 1. Be happy and cheerful at home and at play.
 - 2. Practise self-control and self-reliance.
- 3. Have a sense of fairness in play and games.
 - 4. Overcome unnecessary fears.
- 5. Cultivate kindness to playmates and animals.
 - 6. Learn obedience.

These principles are enlarged upon as the pupil progresses in his studies. By the time he has reached Grade VI the aim of the mental hygiene program is to develop the idea, "A sound mind must have its home in a sound body," and to develop the motto. "What I am to be I am now becoming." Mental hygiene has its foundation in the most elementary education but it does not end there. It is included in the courses and curricula of higher education—for various professional groups, including social workers, teachers, medical students, psychologists, and theological students.

Mental hygiene has been included in the educational programs of many professional groups and it is generally conceded that mental hygiene should be included in the education of the professional nurse. However, at the present time, mental hygiene is a recommended not a compulsory course in our curriculum. In the "Survey of Nursing Education in Canada," published in 1932, Dr. Weir stated, from evidence of questionnaires answered by nurses, that "Psychology applied should receive about 90 per cent more emphasis; that it should not be 'bookish,' but should be based upon the observation and analysis of human problems and actual situations."

Following the publication of the Survey, leaders in nursing education in Canada concerned themselves with compiling a curriculum that they thought would be workable for experimental application throughout Canada. The Proposed Curriculum emphasized mental hygiene throughout the entire course. To begin with,

the aim of nursing education was stated as: "The philosophy underlying nursing education should be in harmony with those educational principles which make for the fullest personal, social, and professional development of the individual." quote further: "The nurse, probably more than any other professional worker, comes in contact with a great variety of life situations, and it is the responsibility of nurse educators to develop in the student those personal and professional qualities which will enable her to make her greatest contribution to public welfare. should be capable of viewing situations objectively and, by the intelligent application of general principles, be able to pursue a course of action based on sound reasoning and careful planning. Because of this ability to make the necessary adaptations she is able to assist in bringing about those changes which, in the light of her best judgment, would seem to contribute to the welfare of the community." Because of the part the nurse is expected to play in the community it is only proper that this should be considered in choosing the subject matter to be included in the curriculum of the schools of nursing. Mental hygiene can not be considered an entity in itself. It can never be isolated from other subject matter. It is dependent upon others for a fuller appreciation of its application. The two subjects most commonly considered as closely related to mental hygiene are psychology and psychiatry.

Psychology may be defined as the study of the workings of the mind. Each one is influenced by his environment and this is very important to the student nurse. It enables her to study herself and aids her in making a satisfactory adjustment. It also helps her to assist her patients in making satisfactory adjustment. In no other profession is the student called upon to make so much adjustment. Sometimes the process has been so simple that one is hardly aware of a change; at other times it has involved a conscious adaptation—absence from

home, dormitory life, differences in routine of personal habits, even the differences in food. Other things to which the student will have to adjust include hospital environment and an intimate contact with sick people of all races, creeds, and stations in life. At the same time she begins an association with the various members of a large institution, the nursing and medical staff, and with visitors.

At a later stage in her education the student nurse studies psychiatry, the care and treatment of the mentally ill. No attempt is made to train specialists but the course should be so arranged as to give her a better understanding of the mentally ill, and a broader appreciation of the principles of mental hygiene. By contact with the mentally ill, those who are marked examples of maladjustment, she is better able to understand slight maladjustment and it will give her a better understanding of the pro-

dromal signs. Clinical experience in psychiatry will be very valuable in that it increases the nurse's tact, tolerance, her understanding of mental illness and of her patients individually. It increases her power of observation and puts her in a position to correct the many prevalent but mistaken ideas regarding mental illness and mental hospitals.

In closing, I shall refer once again to the functions of the nurse: the care of the sick, both those mentally ill and those physically ill; the prevention of disease, both mental and physical illness; and, finally, health education which includes the principles of mental hygiene. We cannot separate mental and physical illness. Each illness presents its emotional and psychological aspects which are too frequently ignored because the nurse is unable to cope with them due to her lack of instruction and experience in psychiatry.

Psychiatric Affiliation

ELLA G. SMITH

IT HAS BEEN the concern for years of the Medical Psychiatric Association to find competent trained personnel to provide nursing care for the mentally ill. Research in psychiatry has made rapid strides in the advancement of psychosomatic medicine. Yet, the preparation of personnel to make the necessary application to the clinical field has lagged. For years much discussion has taken place regarding a well-rounded program of nurse education, yet, while preaching this doctrine, year after year hundreds of nurses have been graduated from schools of nursing without having had any experience in the field of psychiatric nursing.

It is startling to note that many of the nurses in this specialized field have been absorbed in other fields of nursing. Much credit is due the nurses that have remained and endeavored to keep up the standard of nursing for the mentally ill patient. These nurses find that no greater satisfaction can be obtained than watching a diseased mind return to normal and the patient restored to health, returning to the community to carry on at his or her

prepsychotic level.

For the future of mental nursing it was decided to do something to interest nurses in this specialized field. The Registered Nurses Association of Ontario allotted one-half day of the annual convention to a mental hygiene program. This afforded an opportunity to present to the nurses the need for psychiatric training in the basic course of every student nurse. The inspector of Training Schools aroused enthusiasm about such a course during her visits to the various hospitals in the province. As a result, a conference was held to consider the

possibilities of an affiliation. Superintendents of nurses were present from eleven general hospitals and a discussion and outline of the course was presented by the members of the Ontario Hospital staff. The interest kindled resulted in twenty applicants, from seven schools of nursing, in the first class.

The aim of psychiatric experience in the basic course is to acquaint the student nurse with a working knowledge of human behavior, both normal and abnormal, and to give her knowledge of psychiatric nursing. This experience matures the nurse herself and gives her better insight into her personal problems as well as the problems of her patients. She learns to recognize early symptoms of mental disease and becomes more interested in the psychoneurotic patient, resulting in an endeavor to get at the basis of his illness.

The three months' course includes classroom teaching of the following courses: Psychiatry, 12-15 hours; Mental Hygiene, including general and childhood, 15-20 hours; Psychiatric Nursing Problems, including charting, ward problems peculiar to this hospital, 4 hours; History of Psychiatry, 4 hours: Occupational Therapy, 11 hours, consisting of 2 hours' theory and 9 hours in craft work, learning the art of hemstitching, knitting, leathertooling, and basketry: Neurophysiology and Endocrinology, 10 hours; Hydrotherapy, 6 hours. Special lectures include such topics as legal admissions to mental hospitals, hazards in mental hospitals, special treatment for neurosyphilis, etc. Ward clinics number from 10 to 20 hours and include orientation, drug therapy, problems and routines peculiar to ward, fire drill, occupational and psychotherapy for patients, history and classification of patients. Morning circles are conducted by the supervisors, reviewing the ward problems and nursing procedures. Nursing care clinics are conducted on the wards totalling ten or more by the instructors on psychoses peculiar to that particular ward. The student may assist or conduct this clinic under supervision. This enables the classroom instructor to correlate classroom teaching with ward practice. A seminar is conducted at the completion of the course when the set-up for the care of the mentally ill in the province is reviewed. In addition to this teaching the student is expected to complete a behavior study, a symptom record, a personality study, and a nursing care study. After these assignments have been evaluated, an informal conference is held with the student, instructor, and superintendent of nurses. At this time there is an opportunity to determine the student's grasp of her subject and to find out her appreciation of the course as a part of her undergraduate studies. Comments made by the students are of interest:

- (a) A course in psychiatry should be included in every nurse's course. I believe it should be part of the training in the general hospital because it gives a nurse a different viewpoint on mental illness. It prepares the nurse to meet the general public.
- (b) I believe that the course in psychiatry will prove exceedingly beneficial—first, because it has given me greater insight into mental illness and, second, because I am not frightened by the patients or the idea of mental illness. I had never realized that the patients might walk about the wards at will and in a very pleasing environment. I understand how mental illness and physical illness have a bearing one on the other. Now I realize the importance of good mental hygiene, not only in my own life but also in the life of my friends and patients. The course has enabled me to analyze my own feelings in a more definite manner than before.
- (c) I feel that now I know why patients become disturbed and also that they are not as violent as I had been led to believe.
- (d) Psychotherapy, which is essential in psychiatric nursing care, could be adapted equally well to patients in a general hospital.
- (e) I soon realized after visiting Ward One that there were many patients whom one would not necessarily recognize as mentally ill. The general atmosphere amazed mefor example, a piano, a radio, rugs on the floor, drapes on the windows, and flowers in the corridor. I was quite impressed with the Occupational Studio and the parties held there for the patients. For example, the Hallowe'en

costumes which were made by the patients were unusual. The craft work, knitting, and sewing assignments were outstanding and I feel this diversion could be applied in general hospitals, especially during the convalescent period of the patient.

(f) The case study assignment for the student is very beneficial. I really learned the mental disease from which the patient was suffering, and I found I was able to recognize symptoms.

(g) Through my training and experience in this course, I have learned how I may cope with the neurotic patient in general hospitals. I shall attempt to divert their attention from their complaints and introduce occupational therapy. Through this course one can make more suggestions along this line. I feel hydrotherapy might be carried out in general hospitals and thus reduce chemical therapy.

The student attends four psychiatric conferences during the course. At the consultation will be the medical superintendent, the staff doctors, the internes, the Mental Health Clinic psychiatrist and the psychologist. The history and illness of the patient is reviewed and discussed and then he or she is brought to the conference room. He is interviewed by his doctor and is then returned to his ward. Following this interview there is further discussion and the patient is then classified. This teaching enables the student to determine the cause of mental illness and the probable prognosis.

The students rotate from one service to another. This includes four weeks on the female admission floor. one week on the male admission floor. three weeks on the acute mentally ill ward, three weeks on the senile patients' ward, and one week on the continued treatment patient ward with experience in the occupational therapy studio. The nurse spends three days in the Mental Health Clinic where she observes home visits and outside clinics with the psychiatrist, the psychologist, or the social worker. This introduces her to the preventive aspect and the follow-up work in the community. The clinic provides this service for the area that the hospital provides nursing care.

The nursing care of the psychiatric

patient is not heavy physically. A definite routine is necessary as a protection for the patient and hospi-The nurse has to learn the psychology of approach to patients. By winning their confidence and persuading them to assist with ward duties, she breaks through disturbed thoughts and directs their activity into normal channels. The value of psychotherapy and occupational therapy is realized. Psychotherapy is the scientifically directed influence of one mind on another in the interest of health. It may be any procedure such as suggestion or persuasion promoting encouragement and assisting with obtaining self-confidence. It could be anything from a pat on the back to an elaborate mental analysis. It is sometimes called mind cure or faith cure. Occupational therapy is also considered a treatment, just as quinine is a treatment for malaria. It is any activity, either mental or physical definitely prescribed by the physician and guided for the purpose of hastening recovery from disease or injury. It is a therapeutic stepping-stone which aims at: first, recovery of patient; second, adapting a patient to some department or phase of institutional life; third, returning the patient to society.

The student works an eight-hour day and a forty-eight hour week. Nght duty is not assigned as there are fewer educational opportunities in this period. Class hours are included in "duty time."

The final grade received by each student is calculated by the score received on assignments and final examinations. A record is sent to the home school which lists grades in theory and practice as well as a brief narrative summation of the student's adaptability, etc. The incoming record, showing the student's physical record, etc., is kept at the affiliating school.

The thirteen weeks in a mental hospital will do more than introduce the student to mental nursing. It helps her to recognize personality problems within herself, her family, her friends, and her patients. She

will be more tolerant, more tactful, more observant, and better able to adjust to life situations.

The student has the benefit derived from associating with nurses from other schools of nursing and she has to learn to adjust to a new situation where policies are different—for example, the nursing care for the up-patient. She learns that cleanliness, both externally and internally, is as important for this patient as for her bed patient. It requires more teaching, supervision, and close observation, thus better qualifying her for her health teaching program. She learns the therapeutic value of beauti-

fully landscaped grounds in the convalescent care of the patient. The social life of the student is not forgotten. There are many seasonal sports such as tennis, lawn bowling, swimming, boating, skating, curling.

The affiliation courses that have been completed at the Ontario Hospital, Kingston, have been most gratifying, mainly because of the manner in which the students adjusted and became interested in the psychiatric patient. It is believed that psychosomatic medicine is so permeating the picture that the nurse and the physician of the future cannot afford to be without this preparation.

Is Cancer Increasing?

PHYLLIS McPHERSON

Over the past thirty years, the study of cancer has become more and more intensive. No solution to the cause or prevention of the disease has yet been found, but through this intensive study an accumulation of enlightening facts has been gathered which gives a clear picture of cancer incidence in Canada, its prevalence by sex and in various sites, and its relative mortality rating with other diseases.

In 1941 in this country, cancer killed 6,771 males and 6,646 females—seemingly more men than women. However, in proportion to population figures in the Dominion of Canada of 5,900,536 men and 5,606,119 women, cancer deaths were actually higher among women, being 114.7 per 100,000 of the male and 118.5 per 100,000 of the female population.

As a cause of death, cancer is Canada's No. 2 killer, second only to diseases of the heart. Its rating with other leading fatal diseases in 1941 was 13,417 deaths to 26,602 from heart diseases, and a considerably lesser number of 6,072 from tuberculosis, 5,955 from pneumonia, 2,411 from influenza, and 2,140 from diabetes.

This figure of 13,417 cancer deaths in 1941 was an increase over the 1936 census figure of 11,694 in cancer mortality—1,723 more deaths per annum after a five-year period. Here again, however, this appalling increase in fatalities is counter-balanced by a relative growth in population—close to 500,000.

A greater incidence of the disease is also apparent through diagnosis. Many cancer cases in the past were never known to be such. Facilities for accurate diagnosis of certain types of cancer had not been discovered, or perfected to such an extent that they could be relied upon definitely to diagnose cancer beyond question. And, where a margin of doubt existed the case was not reported as "cancer." Internal cancer was, until recent years, extremely difficult to diagnose. The symptoms, as told by the patient to his doctor, were in most cases similar to various other ailments - stomach ulcers, hemorrhoids, or various other aches and pains or manifestations of But the doctor needed ill-health. x-rays and barium fluid to be able to say "there is a tumour." He needed a biopsy to say "it is malignant."

Cancer strikes the aged. Through cures and more effective measures developed in the treatment of other diseases, a greater number of people are attaining an age when cancer is likely to arise. Approximately two-fifths of cancer deaths occur after the age of seventy. More people are living to this age. Since 1900 the overall death rate between the ages thirty to forty has been reduced by about one-half, from forty to fifty by a

third, and over fifty years of age there has been no noticeable reduction. Progress along these lines has been greatest in the infectious disease group; with the lowered mortality rate from infectious diseases, more and more people live ultimately to develop cancer. So, cancer remains a killer. Is it any greater killer than it ever was? Or have improved diagnostic facilities, and increased longevity merely inflated the figures?

Foot Care and Exercise

Take care of your feet because they are your means of getting around. As a first-aid to tired feet, a foot-bath should be a must in before-bed routines. Warm water, plenty of soap lather worked up with a hand brush, followed by a cold plunge or spray will remove the day's accumulation of dirt, perspiration, and dead skin that forms on the feet.

Toenails should be brushed briskly and an orangewood stick should be used on them. A wet pumice stone rubbed over the softened corns and callouses will ensure comfort. A piece of moleskin or a felt ring properly placed retards the regrowth of these annoying excrescences. Use of razor blades on the feet is always dangerous.

The ofollowing exercises, if performed exactly as outlined, can be of great benefit in strengthening weakened muscles and in rejuvenating feet suffering from fatigue. Choose one or two which you can do comfortably and do them every morning first thing out of bed. Three minutes at most is all the time you need. At the start do each exercise five times. As your feet become more proficient increase the number of movements until you can comfortably do each exercise twenty-five times.

To strengthen foot and leg muscles: Place two chairs close together. Sit on one with your legs extended over the other so that the heels are free and the feet are about twelve inches apart. The following motions are performed with the feet only, the legs being held perfectly still: (1) Bring the feet up. (2) Curl the toes down. (3) Push the feet down. (4) Turn feet inward attempting to touch soles together. (5) Pull feet well back holding for a few seconds, and then start all over again with No. 1.

To strengthen the muscles supporting the arch: Take the same position as in the previous exercise. Turn feet inward, making the soles touch. Hold for a count of five, then relax.

To benefit the metatarsal arch: Stand on a large book with toes extended over the edge. Pull the toes down attempting to touch the side of the book with the underside of the toes. Hold for a count of three. Relax. The picking up of small objects with the toes is another useful exercise.

For fatigue and pain in calf and knee due to muscular tension: Stand shoeless with feet parallel and body erect, facing a wall. Place hands on wall at shoulder height and allow the erect body to approach the wall slowly, making certain the heels remain on the ground. Hold for a count of five. If properly done, tension will be felt at the calves. Increasing the distance between yourself and the wall increases the severity of this exercise.

-Health News

Preview

While most mothers try to teach their daughters to be good housekeepers, many nurses who find themselves in the role of superintendent in our smaller hospitals feel somewhat overwhelmed by the multiplicity of housekeeping details for which they become responsible. Elizabeth A. Pearston has come to your assistance with some very concrete suggestions which will help you over many rough spots.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Teaching and Learning in Schools of Nursing

S. R. LAYCOCK, Ph.D.

THOSE WHO ARE RESPONSIBLE for training student nurses in schools of nursing have to concern themselves with four major problems: (1) the curriculum; (2) the readiness of student nurses to profit by instruction and training; (3) the facilities available for learning; and (4) the methods of instruction used.

THE CURRICULUM

Those responsible for the curriculum in a school of nursing are faced with the same problem as are any curriculum-makers. A curriculum is a selected body of knowledge, skills, and attitudes which are considered the most important for the pupils concerned. There are thousands of things which might be taught to nurses. From these the curriculum-maker has to make selections. Everything put into a curriculum is there at the expense of something else left out. If you teach this you cannot teach that. It is vital, therefore, that the curricula material used in a school of nursing should be carefully chosen as that which is best calculated to turn out high-grade nurses.

It is not the purpose of this article to discuss curricula in schools of nursing. The layman, however, often wonders about the number of new subjects which the student nurse has to begin all at once—anatomy, physiology, bacteriology, drugs and solutions, practical nursing, personal hygiene, etc. If a student nurse has all

of these subjects during the first four months of her course while she is making a major adjustment to a whole new way of life, the result may well be mental confusion.

STUDENT READINESS FOR INSTRUCTION

Every instructor in a school of nursing has to consider the question of the readiness of her pupils for instruction. In spite of insisting upon a high school diploma for entrance to schools of nursing there is a wide range in intelligence—that is. in capacity for doing relational thinking—among those who gain admission. Some will, of course, have to be weeded out. As for the rest, the instructor must be able to adapt her teaching to their needs. This means that while pupils are taught in classes the instructor must nevertheless be aware of the individual needs of the students and adapt her instruction accordingly.

In spite of the high school diploma, student nurses exhibit a wide range in the knowledge and skills they bring with them to a school of nursing. Very important among these skills is the ability to read with speed and comprehension. Many students who graduate from high schools read with the comprehension and speed of the average Grade IV pupil. If such students enter a school of nursing they are greatly handicapped in carrying out the study required of

FEBRUARY, 1947

them. Student nurses also bring to their training-period a wide divergence in their ability to study efficiently. Educators find the techniques used in study of increasing importance in students' success in professional schools.

Then there is the question of differences among the student nurses in emotional, social, and intellectual There is increasing evimaturity. dence that the nursing profession is for adults only—that is, for those individuals who have grown up emotionally, socially, and intellectually as well as physically. Among the qualities important for the student nurse are being able to bear tension without blowing up, to become emotionally weaned from home and parents, to observe the ordinary amenities of life and to have friends among one's age-mates, to make up one's own mind, to keep an open mind until all the evidence is in, to take responsibility for oneself and others. to face one's limitations and to come to a working compromise with life. The score of the student nurse on these and other traits is an index of whether or not she is a good risk for the nursing profession.

FACILITIES FOR LEARNING

The first facility for student nurses is that of time. The layman is always puzzled how student nurses who work as much as forty-eight hours a week and often take lectures outside of that period can find the time or energy for serious study. Lack of time for study is a real handicap in training student nurses. There is the question of place. too. It is reported to be still true that some student nurses must do their studying without having an individual desk, reading lamp, and chair. The physical conditions under which study takes place are important for anyone —including student nurses.

Schools of nursing should provide their students with adequate library facilities where books and other supplementary material, including film and other visual aids to study, could be made available.

Finally schools of nursing could

profit by giving their student nurses laboratory periods in how to study so that they might overcome the handicaps in their methods. Merely telling students how to study better is not enough. Rather, they need practice in studying under guidance.

METHODS OF INSTRUCTION

The ideal class in any type of school is a co-operative group where teachers and pupils together are thinking through a topic or practising a skill. The greatest sin of teachers is that they talk too much. They pour information over students like syrup over pancakes. There is too much teacher-activity. Thinking through a topic together where the student is continually challenged to think is the essence of good teaching. The straight lecture method should gradually pass out of use. There is an old saving that "a telling teacher is not a telling teacher." Most factual information is contained in textbooks. Instructors should not merely repeat this. Rather they should use the class period to help the student organize the data in the textbooks and to find new and richer meanings and applications in it. Good teaching is the two-way sharing of experience in which the instructor shares her experiences with the students and they in turn share theirs with the teacher and each other. The net result is a meaningful learning learning which is not parrot-like memorization but learning which functions in the life of the student.

The instructor must have a clearcut awareness of the aim of the lesson. She must know just what new knowledge, understanding, and skill she desires the student nurses to acquire. The purpose of each lesson should stand out clearly in the instructor's mind. One is not likely, except by chance, to hit something not aimed at.

Every instructor of nurses should try to evaluate the results of the class period. She should accept the motto, "If the learner hasn't learned the teacher hasn't taught." should know, at the end of each lesson, just who has learned what. Every good teacher can, to a large extent, do this. She accomplishes this by watching the reactions of every student, testing them by questions, and evaluating their grasp of the material by their participation in the discussion. No good teacher merely "casts bread upon the waters," hoping it will return after many days. Rather she tries to judge just what knowledge or skill was gained by Mary Jones, Jean Brown,

and Betty Smith.

While the teacher must treat each student in her class as an individual she should not teach one student while all the rest do nothing. Rather she must use the difficulty of one student as a means of teaching all the class. When the instructor asks one student a question, there is a danger that the rest will relax and await their turn. The challenge of the question should be thrown out to the whole class first and then one pupil stimulated to answer to all the class, not merely to the teacher. Students should be encouraged to evaluate one another's answers. In addition, when a student has a difficulty, the teacher should see to it that it is the whole group fellow students and teacher—who help to set her straight. If the class is really a co-operative group there will be no difficulty in doing this. Too much time in class is wasted by teaching one pupil at a time. A class is not a series of one-to-one relationships between teacher and students. It is a net-work of relationships in which the teacher becomes a guide to learning rather than a dictator.

What about dictating notes or having pupils copy notes? This is a vicious practice. Often it is merely a means whereby the notes in the instructor's notebook are transferred to the notebook of the student without passing through the head of either. The only notes that have any vitality are those which are "the minutes of the meeting" of the cooperative-group class. The instructor is the secretary-chairman of the group and as the latter thinks through a problem in organized fashion under her direction she writes down the finding of the discussion. should not be copied down as the group goes along. Rather the members should be busy thinking. Before the close of the period, time should be given to copy down the results of the organized thinking of teacher and students. Notes which are simply superimposed on students usually have little real meaning to them. It would be better to have such notes mimeographed and given to the students. They could then be used as a basis for explanation and discussion.

Good teachers do not ask questions the answer to which is obvious. Nor do they ask questions in which the student has a fifty-fifty chance of guessing the right answer by saying "yes" or "no." Good questions stimulate thought. They should be clearcut and definite. Instructors should always accept answers with courtesy whether they are exactly what they wanted or not. Otherwise students will be hesitant to answer next time. All students should be challenged by the question—not merely the bright ones, nor those who sit in front, nor those who put up their hands. It is a way of keeping the group co-operative —a way of bringing everybody into the discussion.

Too much teaching in schools of nursing is on a deductive basis—that is, the principle is given first and then examples are given afterwards. In up-to-date education in schools, great attention is now being given to inductive teaching where a pupil is given a number of particulars and then is led to formulate the rule himself. No longer is he told that there are three kinds of sentencesassertive, interrogative, and imperative—and then given examples of each. Rather he examines a large number of sentences to find what they do, groups them in classes and finds a name to express what they do. All good teachers, including good instructors in schools of nursing, are finding that leading pupils to formulate rules after they have examined particular instances is a much more vital method of teaching in many cases than the old method of first giving rules and then examples.

All good teachers are becoming

alert to the great help they may receive from the adequate use of audiovisual aids in teaching—pictures. diagrams, models, films, phonograph records, and radio programs. There is an increasing number of films which should be of use to instructors in nursing. Good instructors will be quick to take advantage of these. They should seek the co-operation of the Department of Education in their own province. In addition, they should write to Associated Screen News at either Montreal or Toronto for a catalogue of films and explain the type of films in which they are interested. Films can be secured on a rental basis. The Ryerson Press Film Service, of Toronto, and the Film Division, Department of Extension, University of Alberta, Edmonton, are also potential sources of help. Models, pictures, diagrams, maps, charts, books, pamphlets, and phonograph records should also be used extensively. The instructor should remember that these are teaching-aids. They are not a substitute for the teacher. They are not black magic. Their value depends solely on how they are used. To be of maximum service they must be prepared for and followed up by stimulating teaching. Every teaching aid should be judged by the standard of the extent to which it makes clear to the learner what to learn, how to learn, and why the material or skill should be learned.

The good instructor provides for review and drill. No one learns difficult material without some systematic review and practice. The first review of material should be within forty-eight hours since we forget a large part of what we are going to forget within that period, then a review in one week, three weeks, two months, and six months. Drill is important too. It does not need to be dull or boring if carried out in a snappy and interesting manner.

Finally, the good teacher knows that learning is specific—that one learns to do by doing and that one learns what one practises. Definite practice must be given in using the knowledge and skills that are deemed necessary. Moreover, just because learning is specific the instructor must specifically develop such generalized habits as dependability, loyalty, tolerance, cool-headedness in emergencies, and thinking through problems in an organized way. Modern educators do not believe there is much automatic transfer from one situation to another. As a result they recommend that nurses-in-training be given specific practice in as many types of nursing situations as possible and that, in addition, they be given specific training in the use of general principles which they will need to apply in unforeseen situations.

To develop a high professional standard in nurses there must be a high quality of teaching and learning in the schools of nursing. To achieve this is the aim of every good administrator and good instructor in such schools. To that end every bit of knowledge known to modern psychology and to the general field of education should be put into practice in these schools.

Receive Award

Three collaborating authors of the University of Minnesota won the first award of \$1,000 in a national contest sponsored by the McGraw-Hill Book Company for the most outstanding nursing books submitted to them before September 20, 1946. The authors were H. Phoebe Gordon, assistant to the director

of the school of nursing at the University; Katharine J. Densford, R.N., director of the school of nursing and president of the American Nurses' Association; and Edmund G. Williamson, dean of students. Their book, "Counseling Programs in Schools of Nursing," is scheduled for publication in May.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

"Before They See the Light of Day"

ALICE G. NICOLLE, B.S.

HEALTH SERVICE for the child which begins when he enters school is six years too late.

In Ontario, as in many other places, most of our public health programs started with the school health service. To these pioneers we owe much for, in many instances, it is due to their efforts that communities have become increasingly aware that, beginning either to consider the child's health or to teach health habits when he comes to school is too late. School health service has demonstrated its value to the child. It has, however, also proved through the findings of physicians and public health nurses that many of the defects and difficulties of adjustment could have been prevented if discovered and corrected in the early years, long before the child reached school age.

The necessity of preparation for school has been seen for many years by public health physicians and nurses and certain teachers as an insistent need of every child. The summer round-up was an effort to meet the need, and much good work was accomplished by correcting certain physical defects which might have delayed the child's progress in school. Preparation for any new adventure in life is, however, much more than the correction of physical defects. It implies a gradual building of habits, ways of behaving and think-

ing in order to meet the new situation with a reasonable degree of success and happiness. With the young child this can only be achieved by opportunities for healthful living and patient guidance from birth till he goes to school. Entering school in itself requires of the child a great re-adjustment of his daily life. From the familiar surroundings of his home and neighborhood—the almost predictable behavior of his family, his routine of eating, sleeping, and the freedom of play—he suddenly rises early one morning to go to school.

School he finds has a teacher, who, however understanding, is usually a total stranger. Many, if not all, of the children are also strangers. He must conform to a pattern of work which is entirely new, although it may also be interesting. And last but not least, unless he is fortunate enough to live near a kindergarten, he must give up his freedom of movement as well as speech, for even his chair and desk may be attached to the floor. It is often at this time that he has his first health examination, his first immunization, and existing defects are recommended for correction. The wonder is that children progress as well as they do, when one considers the many new and not always pleasant experiences to which they are subjected in their first year of school. Then at best we have wasted six years of learning, not only for the child but for his parents. Yet, we say

FEBRUARY, 1947

Reprinted, with permission, from the Canadian School Journal.

education begins at birth, and his parents are his teachers; at the same time our educational system implies preparation for teaching. Where shall parents secure this preparation for parenthood? It would be interesting and, no doubt, enlightening to gather information from elementary school teachers on the difference in general health, reaction to new situations, and learning capacity among children who have had adequate health supervision from birth, as compared with children who have not had the benefit of this health supervision. Still we have reason to be encouraged, for parents and other citizens interested in the welfare of children are seeking this continuous health supervision for each child from the time of his birth.

During a County Council meeting called to consider the establishment of a county school health program, a lively discussion took place on the health needs of the school child, the limitation of the school health program, and the child's need to be prepared for school that he might benefit from the educational opportunity it offers. A board member, an elderly gentleman of experience, showed great interest in the discussion and came to this conclusion: the preschool children for whom the school service does not provide will next year be school children. The value of preparation for school is obvious. Should we not go back further and have a community health service which provides supervision, even before they see the light of day? This rural board member is right. The care of the school child must begin before he is born, with the education of his parents and the care of his mother during the prenatal period. Although prenatal care is provided by the family physician, the public health nurse in a generalized public health program is prepared to supplement this service as an opportunity for family health teaching and the preparation of the home for the young child. (For whatever a child learns of health elsewhere, he can practise at home only what the home will allow or the family accept.)

Many citizens were shocked at the findings of the local draft boards. during the recent war, at the large number of our young men and women who were rejected because of defects which unfitted them for service. Partly because of this many communities have since been stimulated to an examination of the health facilities and have found them inadequate to meet the need of their people. The result has been an increasing number of requests to the provincial Department of Health for surveys and advice as to the means by which health services could be organized and staffed.

Health units are becoming familiar words in Ontario. Nine units have already been organized in various parts of Ontario, eight of these since 1945. Board members, custodians of their communities' welfare. have seen the need of extending their health activities and, like the elderly gentleman in the county meeting, have shown vision in providing services which include the whole family and its environment. For the program of each health unit is planned to serve all the health needs of its population, both urban and rural, and this is accomplished through the co-operative activities of the medical officer of health, assistant physicians, public health nurses, sanitary inspectors, and clerical staff. Each of these is specially trained to make his contribution to the community program. As sufficient qualified personnel become available the objectives of each unit will one day be realized—a health service through which every member of the community not only will benefit, but will eventually be prepared, through education, to play his part in the prevention of disease and the promotion of healthful living.

What of the cost of a well-conceived health program, developed to meet the needs of the people and in keeping with the best scientific knowledge? The expenditure for such a program stabilizes the investment in education. A child who is well and free from handicaps is enabled to use his educational opportunities to equip

him to be a useful, thinking citizen with the necessary preparation to earn a living and to make a contribution to society. A child, who is frequently absent because of illness or inability to adjust to school, is handicapped, through the loss of educational opportunity, when the time comes for him to earn a livelihood and to take his place as a responsible citizen in his community.

In conclusion, it might be well to consider the present-day trends in health supervision of the child. What are the advantages to him when school health becomes a part of the community program of public health, in which the family is considered when health service is given? The child is known to the health personnel from his birth, so that when he goes to school his health status is known and obtainable. The public health nurse knows many, if not all, of the families in her district; especially is this true of the smaller community or rural area. She has made many contacts in some families, from prenatal care to adult health supervision. In an emergency she may have given bedside nursing care to one of its members - child or adult. It is obvious then that family health service gives the nurse an unusual opportunity to gain the confidence of parents and thus assist them to appreciate the needs of the child. whether it is for dental care, better nutrition, or an understanding of his behavior.

To the parents the family service means a trained person, the district nurse from whom they can seek health guidance. It prevents the confusion which may arise as to the teaching they should follow when, as in specialized services, school, tuberculosis, or infant hygiene, several nurses visit the home within a short period. In certain municipalities in Canada, particularly in the larger urban areas, a separate group of public health nurses, known as visiting nurses, are also responsible for the greater part of bedside nursing. There is an understanding co-operation between these two groups based on a

common background of preparation and a mutual interest in the welfare of the family.

The school staff benefits from the close contact with the work of the health department personnel, in terms of an added interest in their own health as well as the child's. It is an opportunity for each teacher to build a background of authentic health knowledge concerning the health conditions and the measures taken to ensure the health and safety of their own community.

The rapid development of health services has increased the responsibilities of all adults who work with and for children. The school teacher has been asked to assume an increasingly large share of health teaching and supervision of the pupils under her care and the response has been magnificent. Together, teachers and nurses are helping to bring to every child the opportunity of health and some measure of equality which may come to them in no other way.

The teacher has an unparalled opportunity to observe her pupils and daily to be on the alert for deviations from what is normal for each child, both his physical condition and his behavior. Her early observations shared with the health personnel will often prevent serious illness for the child and the spread of infection to others in the school. It may also prevent the development of handicaps since early treatment offers the greatest hope of cure.

In the rural areas, especially where the child because of long distances must bring his lunch to school, the teacher can be the first line of defence in the campaign for improving the nutrition of the school child. To the observant teacher the child's lunch box can often account for his lack of energy and progress or his frequent absence from school. A hurried and many times inadequate breakfast, a poor lunch box, and an evening meal lacking in the essentials for good nutrition needed by the child for growth and development may make the difference between success and failure both in school and later life.

A tiny child in a small school, whose teacher said she was dull, was observed during the war years with a lunch of "four cookies." She walked two miles each morning and evening to reach school!

In some areas the school lunch has already been supplemented or a noon meal provided. Teachers and children have been given the willing co-operation of trustees, board members and parents, while the public health personnel and often a nutritionist have acted as consultants to further the project.

Physical health is important, but it is not enough to strive for physical perfection. Without mental and emotional health or stability, it may mean physical strength without judgment; a liability rather than an asset to the individual and those with whom he is associated.

ne is associated.

Health personnel everywhere is beginning to realize that mental health is as great a responsibility as the prevention of other conditions and diseases, perhaps greater. And the time to start preventive measures is before the child is born—with the education of his parents. The home, where the child lives and learns, is the first area in prevention to which we must direct our attention. On this preparation will the school have to build.

Perhaps the greatest need of all children today is that we should understand them and their needs as children.

Cilia Cil.

We are all blind until we see that in the human plan

Nothing is worth the making if it does not make the man.

Why build these cities glorious if man unbuilded goes?

In vain we build the world unless the builder grows.

-EDWIN MARKHAM

A Nurse's Prayer

Lord of this earth, touch every nurse's heart; Kindle in each, desire to play her part— To build a world that's patterned to be free, A world where peace will reign, and liberty.

Give us the women, strong in faith and zeal, The women who will care, and truly feel Theirs is a task that they alone can do Because they have conviction, deep and true.

Give us the nurses, in our day and age, Whose names will live on future's history-page, Because a passion for their country's sake Will make their selfless giving truly great.

Give us women, Lord, who dare to claim Thee as their Guide, whate'er their rank or fame,

Women whose faith will hold in peace or strife, To give them courage for their tasks in life.

Give us the nurses who will dare to live On that new level where they learn to give Not just their time, but everything of self, To bring new life to nations, and new health. Make us the women, Lord, You need this day, And for Your strength and guidance we would pray.

We pledge our lives to build a better world, Where flags, for Freedom's sake, will be unfurled.

-EDNA EARLE LEVELTON, R.N.

Fried Foods

As long ago as 1927, scientific research into the digestibility of fried foods revealed that we are wrong in condemning them. In that year, two investigators studied the digestibility of potatoes cooked in various ways. Their conclusions were that the starch of the pan-fried potato is more easily digested than that of the French-fried, and that of the French-fried more easily than that of the boiled variety. When properly cooked, not simply soaked in hot fat, it was found by fluoroscopic observations that the fat actually facilitated the rate of digestion! Within recent time, further studies have been made of the digestibility of other fried foods. The original findings were amply confirmed.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

La Lutte Anti-Tuberculeuse

SUZANNE LEBLANC

La Lutte anti-tuberculeuse a déjà à son actif de consolantes réalisations, grâce à des initiatives privées qui en furent les promoteurs en défrichant le terrain, parfois dans des conditions bien difficiles, en vue de sauver le capital humain qui de jour en jour, au milieu du bouleversement mondial, nous apparaît plus précieux. Rendons hommage au dévouement et aux mérites de ces généreux philanthropes.

Mais nous admettrons facilement qu'il reste beaucoup à accomplir. Dans la seule Province de Québec, il est reconnu que la peste blanche préleve annuellement un tribut d'environ 3,000 vies. En face de cette triste constation, demandons-nous s'il n'y aurait pas lieu de laisser de côté d'autres problèmes, pour donner la primauté à une grande enquête sur les causes de cette terrible hécatombe afin de trouver les moyens d'enrayer le fléau qui fait une telle trouée dans notre génération montante.

Les autorités gouvernementales, ces dernières années, ont largement secondé les premiers travaux philanthropiques, accomplissant de grands et sérieux efforts par des octrois fédéraux et provinciaux, dans le but de lutter efficacement contre ce fléau dévastateur. C'est un devoir social qui doit se faire en collaboration, donc: professionnels, ouvriers, familles—tous doivent coopérer à cette oeuvre fraternelle et de pur patriotisme, convaincus que la prévention est possible et même que la guérison définitive est réalisable.

Au lieu d'user nos énergies à des tentatives éparses, il faut unir nos moyens physiques, intellectuels, et pécuniaires. Il faut adopter une attitude d'ensemble avec un programme bien défini pour prendre notre place dans cette grande armée qui s'emploie à limiter tant de ravages. Notre peuple qui a mobilisé tout son actif humain, qui a dépensé l'argent avec tant de prodigalité pour fins de guerre où tant des nôtres laissèrent leur vie, aura-t-il la sagesse et la prévoyance d'en dépenser pour la survie de ceux qui restent?

Avoir en main dix milles de dollars pour réaliser tout le plan anti-tuberculeux, certes ce ne serait pas suffisant, mais ce serait d'absolue nécessité pour contribuer à cette oeuvre humanitaire et ne pas la laisser s'effondrer tristement.

Cette souscription, comment la partager? Je laisse aux experts ce calcul. Je me contenterai d'y poser quatre grands objectifs: prévention, dépistage, hospitalisation, réhabilitation:

1. Prévention: Les phases d'expansion et de déclin de la tuberculose semblent associées d'une manière intime à l'évolution sociale. Elle prend avantage des circonstances défavorables. Il faut, à tout prix, éclairer le peuple, car si le B.K. est la cause déterminante de cette maladie funeste, la cause prédisposante, chez-nous, n'est-elle pas l'ignorance? L'éducation du public doit se faire par la presse, la radio, la distribution de circulaires, de brochures, de tracts,

FEBRUARY, 1947

des conférences dans les écoles, devant les sociétés médicales, et les clubs sociaux, le cinéma, les séances récréatives, etc.

L'éducation, c'est bien, mais il faut plus. Voir à procurer à chacun sa part de soleil, d'air pur, de lumière; lui assurer une alimentation rationnelle, un travail proportionné, un

salaire meilleur.

Que de facteurs à considérer et à améliorer! Que de palliatifs à apporter: Multiplier les parcs, terrains de jeux, piscines, camps de santé, cantines scolaires, surtout faire disparaître les taudis malsains, les usines insalubres, etc.

Enfin, comme prévention, la campagne du B.C.G. mérite une mention spéciale. La vaccination, semble-t-il, a la chance de parer aux dangers persistants de contamination. Et la clinique du B.C.G.—souhaitons-lui, non seulement de durer, mais de grandir.

Assurément, la santé publique coûte cher, mais la maladie coûte davantage.

2. Dépistage: Pour opérer le dépistage intensif, les ligues, dispensaires, unités sanitaires sont utilisés; la population est invitée à subir périodiquement, et sans frais, un examen médical; les industriels, les patrons de manufacture sont priés de faire examiner leurs employés. Ce moyen est facilité par des cliniques ambulantes dirigées par la ligue antituberculeuse, composées de médecins, de techniciens experts, munies d'appareils fluoro-radiographiques. Le personnel enseignant doit fournir un certificat d'examen pulmonaire, et exiger celui des élèves. Accessoirement, se pratiquent les réactions tuberculiniques.

3. Hospitalisation: Voilà un autre objectif très important. Que signifiera un sérieux dépistage, s'il n'y a pas assez d'institutions pour isoler, traiter les malades. Préventorium pour enfants et adultes! Sanatoriums-hôpitaux! Sanatoriums autant de nécessités-construire, outiller, maintenir un personnel compétent. Améliorer les institutions existantes. Encourager les interventions chirurgicales, les recherches de la chimie, dans le seul but d'assurer au patient du confort, des bons soins, une médication curative, un traitement radical. Oh! quelle tâche! Elle ne doit pas être impossible.

4. Réhabilitation: Elle doit commencer au sanatorium. Il faut fournir aux tuberculeux tous les movens de s'instruire, d'apprendre un métier proportionné à leurs forces, afin qu'au sortir du sanatorium, ils puissent se diriger vers un emploi lucratif en relation avec leur état. Aussi, que de nombreuses oeuvres ont été fondées: amicales de malades, associations d'hygiène sociale, oeuvres d'assistances, ateliers de réadaptation. Suggérons aussi, la formation d'un service social dans tous les sanatoriums, d'un service de placement. des assurances sociales, des syndicats corporatifs, etc.

Voilà, en résumé, le plan de la lutte anti-tuberculeuse que notre peuple jeune, fort, intelligent, voudrait voir réaliser pour monter la guerre la plus pressante, celle qui détruira ce fléau

social qu'est la tuberculose.

En terminant ce travail qu'il me soit permis de formuler un voeu: Que ces dix milles de dollars soient accordés à la ligue anti-tuberculeuse pour ses activités de 1947.

Note: Les infirmières de la Section de l'Hygiène Publique organisèrent l'automne dernier, un concours parmi les élèves de nos écoles d'infirmières. Le sujet était "Si vous aviez dix milles de dollars pour combattre la tuberculose, comment les employeriezvous?" Les buts de ce concours étaient les suivants: (1) D'attirer l'attention de toutes les élèves de nos écoles sur la campagne antituberculeuse. (2) De faire réaliser le coût de

la maladie même pour le citoyen en santé. (3) De faire de nos élèves, à l'hôpital et plus tard chez les malades, des apôtres de la lutte anti-tuberculeuse.

La coopération n'a pas été celle que nous espérions, mais la qualité des travaux présentés est à souligner et c'est avec plaisir que le jury a accordé les prix suivants:

1er prix: \$15, offert par l'Association

Divisionnaire no. 12, mérité par Mlle Suzanne Leblanc, Hôpital du Sacré-Coeur, Cartierville. 2e prix: \$10, offert par la Section d'Hygiène publique de l'A.G.M.E.P.Q., mérité par Mlle Anne-Marie Cayouette, Hôtel-Dieu, Chicoutimi. 3e prix: \$5.00, offert par Mlle A. Girard, directrice de l'Ecole des Infirmières Hygiénistes de l'Université de Montréal, mérité par Révérende Soeur Cécile de Rome, Hôtel-Dieu, Chicoutimi. 4e prix: Un abonnement au Canadian Nurse, offert par Mlle A. Déland, directrice du Service Social à l'Institut Bru-

chési, mérité par Mlle Augustine Fournier, Hôpital St-Joseph, Rimouski. 5e prix: Un abonnement au Canadian Nurse, offert par Mlle Suzanne Giroux, visiteuse officielle des écoles d'infirmières, mérité par Mlle Yolande Paradis, Hôpital St-Luc, Québec.

Un volume, "L'Infirmière Visiteuse," offert par Mlle A. Martineau, assistante de l'infirmière en chef, Service de Santé, Montréal, à toutes les candidates ayant pris part au concours. Le sort a favorisé Mlle M. A. Rogeau, de l'Hôtel-Dieu, Sherbrooke.

The Provisional Council

The representatives of university schools met for the first time in Montreal on June 20, 1942. Three days later these representatives again met and the Provisional Council of University Schools and Departments of Nursing came into being.

The objectives of the Council were: (a) To decide upon the form of a permanent association of university schools of nursing.

(b) To determine desirable standards for university schools of nursing represented by members of this Council.

(c) To strengthen the standards of existing university schools of nursing and to support the development of future university schools of nursing where desirable conditions exist. (d) To strengthen the relationships between university schools of nursing in Canada and

other countries.

An annual membership fee of two dollars was agreed upon. Meetings were to be held yearly. Two standing committees of the Council were named: a committee on policy and a committee on studies. Miss K. W. Ellis was elected president, Reverend Mother Allaire, vice-president, and Mary Mathewson, secretary-treasurer. Miss Florence Emory became chairman of the committee on policies. A questionnaire, forwarded to all members of the Council by Miss Emory's committee, revealed a diversity of opinion on all questions asked — the form the organization should take, its financial support, etc.

A further study of standards was proposed

in 1944. These were to include:

(a) General standards for university schools of nursing, including organization and administration, qualifications of faculty entrance requirements, student records, etc.

(b) The organization and content of theory and practice in hospital and school of nursing courses, undergraduate and graduate.

(c) The organization and content of theory and practice of public health nursing courses.

Committees were formed to study the graduate and undergraduate nursing courses and the public health nursing courses. The committee on policies was to study general standards for university schools. In March, 1946, the committee studying

graduate and undergraduate nursing courses ceased to function. It was replaced by a committee to study all university post-graduate courses in teaching, supervision and administration in hospitals and schools of nursing. Another committee was created to study all basic courses in nursing which had a university connection.

a university connection.

In order to assist members in their thinking prior to the general meeting on July 1, 1946, it was decided to bring to their attention the points on which standards should be laid down—the organization of the school, resources and facilities, and the selection of students. The work of the study committees was temporarily suspended pending a possible reorganization of the Council.

a possible reorganization of the Council.

At the general meeting in Toronto on July 1, 1946, the need was expressed for a medium through which those who are teaching in university schools could discuss common problems. It was decided that the group continue under the present plan of a Provisional Council for another two-year period. The objective for this period is to discover the common problems of university schools and departments of nursing. Suggested topics for discussion are to be sent to the secretary by the end of January, 1947. These suggestions will be summarized and forwarded to the members along with the agenda. It was thought desirable to plan for a meeting in May or June, 1947.

The president, Miss K. W. Ellis, and vicepresident, Reverend Mother Allaire, were returned by acclamation. Miss H. E. Penhale was elected secretary-treasurer.

For Fillings

Acrylic resin, a material widely used in the United States as a base for false teeth, was developed by the Germans during the war as a permanent filling for direct use in a quickly hardening plastic state in prepared cavities. Fillings inserted in 1943 have been found to be in excellent condition.

Interesting People

Marie Louise Gabrielle Charbonneau, recently appointed as assistant professor and co-ordinator of field experience with the School of Public Health Nursing, University of Montreal, was born in Montreal of French and Scottish parents. She received her preliminary education in the convent of the Soeurs des Saints-Noms de Jésus et de Marie. Graduating from Hotel-Dieu de St. Joseph, Montreal, in 1938. Miss Charbonneau received her diploma in public health nursing the following year from the University of Montreal. She holds the degree of Bachelor of Letters from the same university and has done considerable studying at the Catholic University of America in Washington, D.C.

Miss Charbonneau engaged briefly in private and general staff nursing before she joined the staff of the "Société des Infirmières Visiteuses." She served with the Montreal Health Department for five years prior to her new appointment. She is vice-president of the Association Jeanne-Mance. For relaxation she turns to music and sports—skiing, swimming, and tennis.

Dorothy Maxine Ward, who graduated from the Royal Victoria Hospital, Montreal, in 1941, has been appointed an instructor in the Faculty of Public Health at the Univer-

Garcia, Montreal

GABRIELLE CHARBONNEAU

sity of Western Ontario, London. Miss Ward received the degree of Bachelor of the Science of Nursing from Western Ontario in 1942, majoring in public health nursing. After a year with the Victorian Order of Nurses for Canada at Kitchener, Ont., she engaged in school nursing at Lisgar Collegiate, Ottawa, Ont.

Miss Ward is particularly fond of tennis and skiing. She was one of the leaders in a young people's group which bodes well for her new activity.

Jean MacLean has been appointed supervisor of Red Cross Outpost Hospitals in the Nova Scotia Division of the Canadian Red Cross Society. Miss MacLean is a native of Pictou County, N.S., and received her early education in New Glasgow. She graduated from the Toronto General Hospital from which she received the Mary Agnes Snively Scholarship in 1935 and qualified in the certificate course in teaching and supervision at the University of Toronto. She returned to her home school as head nurse of the fracture and neuro-surgical ward for five years. In 1941 she became supervisor and clinical instructor in general surgery there, leaving in 1943 to join the R.C.A.M.C. During most of the two years that Miss MacLean was in the service she was stationed in Canada. Upon



DOROTHY M. WARD



JEAN MACLEAN

her discharge, she enrolled for the course in administration in schools of nursing at the McGill School for Graduate Nurses receiving her Bachelor of Nursing degree in 1946.

Marion Crawford Story has been appointed provincial director of the Junior Red Cross for Saskatchewan. Born in England, Miss Story was educated in Edmonton, graduating in 1928 from the University of Alberta Hospital. After a brief flurry of general staff nursing in Edmonton and in California, she joined the school nursing staff in Edmonton where she worked from 1930 until her enlistment in the R.C.A.M.C. in 1942. During a year's leave of absence in 1935, Miss Story received her training in public health nursing at the University of Toronto.

Miss Story's war service in the internment camp in Medicine Hat preceded going to England and Belgium, with a brief interlude on the hospital ship, Lady Nelson. On her discharge, she returned to the University of Toronto for advanced work in public health nursing.

Through the years Miss Story has always participated in various association activities. She was chairman of the public health section of the Edmonton Branch of the A.A.R.N., treasurer and corresponding secretary of the University of Alberta Hospital Alumnae Association, a member of the University of Toronto School of Nursing Alumnae Association, and of the Nursing Sisters' Association. She is also a member of the Regina Business and Professional Women's Club. Reading and handiwork fill her leisure moments.



MARION C. STORY

The new chairman of the national Committee on Private Duty Nursing, replacing the old General Nursing Section, is Barbara Key of Hamilton, Ont. Miss Key is well fitted by her experience to give excellent leadership to this group of nurses. After graduating from the Hamilton General Hospital, she engaged in private duty for many years. Miss Key has been keenly interested in the development of community nursing registries throughout Ontario. Through her chairmanship of the Board of Directors of the Hamilton Registry, she has had an excellent opportunity to study the most effective methods of operating such registries.

Miss Key had a great deal to do with the demonstration course in practical nursing as



BARBARA KEY



ADA SANDELL

sponsored by the Hamilton Community Nursing Registry under the egis of the R.N.A.O. She was responsible for the details of arrangements and saw the course through to its successful conclusion. Miss Key is also a member of the Health Division Committee of the Council of Social Agencies. Her brief leisure periods give her opportunities for reading and knitting—when she can find the wool! She is also an enthusiastic photographer.

Ada Sandell is preparing to return to the mission field in Korea where she labored for so many years before the war. Born in England, Miss Sandell spent her early years in Magog, P.Q. In 1922, she graduated from Lamont (Alta.) Public Hospital and, after various preparatory courses, was appointed to a United Church mission in West China. Unrest and civil strife deterred her departure



MARGARET G. KENNEDY

for two years during which she engaged in social service work in Copper Cliff, Ont. When she finally reached China in 1926 the upheaval in the inland areas was such that she was transferred to Hamheung, Korea.

Miss Sandell organized the nursing profession in northern Korea, establishing the first school of nursing in that part of the country. Until war interrupted her activities in 1940, her work progressed. During the war years, Miss Sandell served as superintendent of nurses at the Lamont Public Hospital.

When she returns to Korea, Miss Sandell will not be able to go back to her former school as that part of the country is under Russian occupation. Her present task will be to assist with the organization of a nursing department at Ewha University in Seoul. Our good wishes go with her. May her work prosper!

Margaret Glen Kennedy has undertaken an interesting piece of work at the Queen Elizabeth Hospital, Toronto, which is devoted to the care of chronic invalids. Miss Kennedy will be educational director and will have charge of a broad program for the entire nursing staff—graduates and assistants. She will demonstrate the value of this type of hospital in the general health program of the community, correlating the work of the nurses in the hospital to the total picture.

Miss Kennedy graduated in 1936 from the Toronto General Hospital. She engaged in private duty nursing until her enlistment with the R.C.A.M.C. in 1940. She saw service in England and Italy. On her discharge she joined the Victorian Order of Nurses, completing her public health nursing course at the University of Toronto last year.

Preview

Should nutrition be included as an important part of our public health programs? Off hand, most of us would give a simple answer, "Yes, of course." How many of us are well informed on the actual nutritional status of our citizens? Do we know what advice should be given? The first of a series of articles on nutrition, prepared by members of faculty of the University of Toronto, will give us some of the answers next month. Dr. E. W. McHenry, head of the Department of Nutrition, will start the series off for us.

Notes from National Office

World Health Organization

THE FOLLOWING INFORMATION is summarized from the November, 1946, Bulletin of the International Council of Nurses:

The necessity for co-operation with the World Health Organization and the United Nations Educational, Scientific and Cultural Organization was stressed. Miss Schwarzenberg has had interviews with Dr. A. Stampar, chairman, and Dr. G. B. Chisholm, secretary general of the World Health Organization and an application for the most desirable form of co-operation has been made.

The twenty-two functions of the World Health Organization give us a clear idea of its objectives as outlined by Elmira B. Wickenden, adviser member of the U.S. delegates to the International Health Organization:

- To act as the directing and co-ordinating authority on international health work.
- 2. To establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administration, professional groups and such other organizations as may be deemed appropriate.
- 3. To assist governments, upon request, in strengthening health services.
- 4. To furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments.
- To provide, or assist in providing, upon the request of the United Nations, health services.
- To establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services.
- 7. To stimulate and advance work to eradicate epidemic, endemic and other diseases.

- 8. To promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries.
- 9. To promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene.
- 10. To promote co-operation among scientific and professional groups which contribute to the advancement of health.
- 11. To propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objectives.
- To promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment.
- 13. To foster activities in the field of mental health, especially those affecting the harmony of human relations.
- 14. To promote and conduct research in the field of health.
- 15. To promote improved standards of teaching and training in health, medical, and related professions.
- 16. To study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital service and social security.
- 17. To provide information, counsel, and assistance in the field of health.
- 18. To assist in developing an informed public opinion among all peoples on matters relating to health.
- 19. To establish and revise as necessary international nomenclatures of diseases, of causes of death, and of public health practice.
- To standardize diagnostic procedure as necessary.
- 21. To develop, establish, and promote international standards with respect to food,

FEBRUARY, 1947

biological, pharmaceutical, and similar products.

22. Generally to conduct all necessary action to attain the objective of the organization.

Visit to Hospitals in Great Britain

The following information, concerning the visit of the general secretary, Canadian Nurses' Association, to Great Britain, was contained in a report as presented to the Executive Committee, December 5-7, 1946:

Britain, like every other country, is in a state of confusion in so far as nursing is concerned. Nurses are in short supply, hospital beds are filled to overflowing, and health services are expanding everywhere. If and when the new Health Service Bill is implemented the nursing service needs will be increased beyond any possibility of meeting these needs.

The Ministry of Health, driven to desperation, has taken the matter in hand in a most practical manner and has set up a committee to analyze the nursing problems with a view to making recommendations which will remedy the situation as quickly as possible. Unfortunately, however, at the time we interviewed the Chief Medical Officer of the Ministry of Health we were informed that the committee making the study will produce a confidential report and although we were given a great deal of information we were requested to treat this as strictly confidential.

The Ministry of Health set up a steering committee to initiate a study of the nursing situation. This committee consists of the following: Sir Robert Wood, Minister of Education, who is chairman of the Committee, with representatives from the Ministry of Health, Ministry of Pensions, Ministry of Labor, and the Board of Control Committee; (the latter corresponds to the Department within our Government responsible for the administration and hospitalization of the mentally ill).

The actual study is being conducted by a small committee known

as the working party, consisting of two nurses, experienced and able women, a medical doctor, and the director of the working party, Dr. Cohen, who is an economist and psychologist. The working party has been busily engaged in carrying out the work connected with the investigations, analyzing these, and preparing the reports for the steering committee.

The first step in the study consisted in:

1. An examination of all previous reports on the nursing situation: (a) Lancet Commission; (b) interdepartmental report; (c) Horder and Rushcliffe reports; (d) report on social medicine; (e) reorganization of nursing by G. V. Carter.

2. Job Analysis: (a) Investigation of the student nurse wastage; (b) investigation of recruitment program for student and assistant nurses and the structure of the nursing profession; (c) pre-nursing education; (d) methods of training; (e) organization of personnel in hospitals and other institutions; (f) comparative programs in other countries.

Conferences were held with Dr. Cohen and his assistant. Dr. Cohen has initiated the testing program for student nurses and is also conducting the investigation on the nurse wastage which incidentally amounts to the alarming figure of an annual 60 per cent wastage for student nurses in the hospitals in Great Britain. The wastage of students in Canada for 1944 was 1,200 or 12 per cent.

The study covers the period 1937-45 and includes a report of the students enrolled for each year. The breakdown of the numbers leaving during the first year is along these lines: (a) number who leave before entering wards; (b) number who leave after entering wards; (c) number who leave in second and third year and subsequently and the total.

Causes of wastage include: sickness, marriage, failure in examinations, discharge by hospital, resigned and reasons for resignation, other causes.

Interviews have been held with as many students as possible who for the above reasons cancelled training and much valuable information has thus been obtained. A psychologist is making the job analysis, in co-operation with an experienced nurse who interprets the nursing situation, on quite an extensive scale. The analysis includes: (a) the duties of nurses; (b) length of time spent on duties (comparative weight is given to each duty); (c) functions involved in carrying out duties; an endeavor is made to relate functions to phases of training in the existing syllabus, and to relate these to the aptitude of the nurse.

The psychologist endeavored to assess the qualities of personality necessary at a minimum level for successful training and an analysis of qualities in individual fields in relation to other fields of nursing.

Hospitals selected for the job analysis study were representative of general or special fields of nursing. Procedure consisted of: conference with matrons of hospitals from whom general information regarding the hospital and its organization was obtained. Each special ward representative of that field of nursing was visited and conferences held with sisters in charge of wards, to whom the program was explained and information sought.

The sister outlined in detail the duties of each worker on the ward; students were observed as they performed special duties and thus the psychologist obtained a general understanding of the extent of the scientific knowledge necessary and the skill required by the student to perform these duties.

It was interesting to find the psychologist had taken into consideration the physical facilities of each hospital ward and was quick to discover the discrepancies in the physical lay-out of the ward due to faulty planning, etc.

It was especially interesting to find she had made a diagram of each ward showing the relationship of the utility rooms (called sluice rooms in Great Britain) to the ward itself. The psychologist was very critical of the hazards arising from the physical factors which in turn played such an important part in the nursing ser-

vice and actual nursing care of the patients.

The report of the working party is to be ready for submission to the Ministry of Health by December 31, 1946. What will happen from there on will be awaited with keen interest.

Preparation of the Assistant Nurse:

Mrs. Bennett, chief nursing officer
of the Ministry of Labor, arranged for
and accompanied me on my visit to
Chelmsford and St. Margaret Hospitals at Epping in Essex County.
Chelmsford Hospital operates for the
care of the chronically ill. Assistant
nurses are assigned to this hospital
following their preliminary training
at the Pre-training Centre.

At Epping the student is enrolled as an assistant nurse and spends one month. During this period she receives some theoretical instruction and is taught the following nursing procedures: ward management, bedmaking, bed baths, general care of the patient, taking temperature, pulse, respiration, etc. I observed a class being taught at Epping where an experienced sister tutor was in charge. The teaching was being given very slowly and on a very elementary level. The class consisted of twelve students. the majority from Ireland, all radiating abundant health, and all with varying backgrounds of education and experience.

A committee, composed of matrons, interviews the applicants for training as assistant nurses. If they find an applicant with more than average educational preparation and having the necessary qualifications for general training, she is advised to enter a school of nursing offering general training. They are also informed that having successfully completed the second year assistant nurse training, they may, if they so desire, enter general training. A time allowance is made for previous training and this training is also considered in lieu of complete high school.

There are not sufficient numbers of applicants for the assistant nurse courses. The reasons given were as follows: According to the Rushcliffe salary schedule, the salaries of assis-

tant nurses and domestic workers are almost equal. During training the assistant nurse receives £55 or \$220 the first year and £65 or \$260 the second year. If assigned to a tuberculosis sanatorium, they receive £65 the first year and £75 the second year. Following training they receive £95 which is increased by £5 bi-annually until they reach a maximum of £160. It requires a period of twenty-two years before this salary level is attained. The attitude of the professional nurse group is definitely one of superiority and the assistant group are naturally somewhat resentful.

From my observation of the quality and extent of the teaching program and experience being given the assistant nurse, also from discussion of the course with experienced sister tutors and matrons, I am of the opinion that the course being given the assistant nurse in Great Britain is very similar to the practical nurse course being given in Canada in a nine-month to

one year period.

General training for the State Regis-

tered Nurse:

Visits to the London, St. Thomas, Westminster, and Kings College Hospital, and to the Sector hospitals connected therewith, were arranged on my behalf by Dame Katherine Watt, British Ministry of Health.

Miss M. G. Lawson, deputy chief nursing officer, accompanied me on some of the above visits. My visit to the London hospital consisted of observing classroom and ward teaching. A full day was spent observing

what is called a Study Day.

The London hospital introduced a new study day scheme of training in August, 1945, designed to ensure that the student nurses were spared the strain of theoretical training and practical ward work at one and the same time. The study day is spent in attendance at doctors' lectures followed by nursing classes.

The student nurse has an elevenweek period in the preliminary training school followed by three periods spaced at intervals during her three years' training in which she has a weekly study day. These study day periods are spread over the three years of training and each student nurse has a total of fifty-three study days during this time. This total is made up of three sixteen-day periods in the first, second, and third years respectively, and one four-day period before the final State examinations, with one day on entry to the hospital to introduce her to it.

The preliminary training school of eleven weeks allows for 202 hours of theoretical and practical instruction in nursing and the basic sciences, 31 hours for physical training, 50 hours for housewifery and gardening, and

88 hours for private study.

There are four preliminary school terms in the year held from January to March, April to June, July to September, and October to December. The number of students admitted to

each term is from 40 to 45.

Each student receives a total of 351 hours of classroom lectures and demonstrations, including practice demonstrations over a three-year period. Compared to the Proposed Curriculum for nurses in Canada or the American Curriculum Guide, this seems very limited indeed. It must, however, be remembered that, in addition, a great deal of ward teaching is actually given on the wards by the sister in charge. For the most part these sisters were more experienced than the majority of head nurses and supervisors in Canadian schools of nursing. I observed on many of the wards, during the early morning hours when patients were receiving morning care, and the quality of nursing care being given compared very favorably with that observed in many Canadian and American hospitals.

From these observations and from conferences with matrons, sister tutors, and sisters in charge of wards, my

impressions are as follows:

Voluntary hospitals in Britain conducting schools of nursing have not endeavored to increase the theoretical content of the curriculum as we have in this country. They are of the opinion, and we cannot deny there is basis for this opinion, that student

nurses who are required to give so much nursing service to hospitals cannot possibly obtain maximum benefit from a greatly increased

theoretical program.

On the other hand several British matrons who were associated with American and Canadian nurses, both in the army and with UNRRA, stated that the nurses from this continent seemed very well prepared for public health nursing. Special reference was made to the nurses who had trained in collegiate schools of nursing and who had demonstrated real ability to organize and carry out an excellent program of public health nursing.

Due to the limited time at my disposal it was unfortunately necessary to cancel several appointments and further visits of observation which had been planned by Dame Katherine Watt. The experience obtained from even four short weeks (each day filled to overflowing) has already proved profitable and will. I feel sure. justify in the future the time so spent.

Executive Committee Meeting

A meeting of the Executive Committee, Canadian Nurses' Association, was held in Calgary on December 5-7. 1946. Those present included the officers, the chairmen of standing committees and the presidents of all provincial registered nurses' associations except Prince Edward Island. The various reports will be summarized for the March issue of The Canadian Nurse.

Resolutions arising from the meeting are as follows:

1. Whereas the nursing profession over a period of years has attempted through legislation to develop a standard of nursing education and service to meet the ever-increasing health needs of the country, by higher educational entrance requirements and continuous improvement of clinical teaching facilities:

AND WHEREAS in view of the present shortage of nursing service, certain interested groups have suggested that the number of nurses might be increased by lowering the entrance standards and by re-opening schools of nursing in hospitals which previously were considered inadequate as practice fields:

AND WHEREAS it has been shown that in the years 1940-45, with a general rise in the educational requirements, the number of students in the approved training schools of the country increased by 45 per cent:

AND WHEREAS the present approved schools can accommodate more stu-

dents:

Be it resolved, That the Executive Committee of the Canadian Nurses' Association go on record as being strongly opposed to the lowering of educational requirements for entrance to schools of nursing, and to the opening of schools in hospitals without proper teaching and clinical facilities.

2. Resolved, That the power to administer the affairs of the association as laid down in this by-law shall not involve any change of policy on the part of the sub-committee or include power to incur any extraordinary expenditure. Copies of the minutes of the meetings of the subcommittee shall be sent to all members of the Executive Committee within a period of two weeks from the date of each meeting. The proceedings of each meeting of the subcommittee shall be ratified at the next meeting of the Executive Committee.

3. Resolved, That the British Nurses' Relief Fund be continued, and that the provincial associations, the Nursing Sisters' Association, and any other interested groups be notified of the existing needs; also that the provincial associations notify National Office within two weeks if they can make a contribution toward bringing a European nurse to the International Council of Nurses Congress.

4. Whereas there has been widespread discussion of the new tax regulations for married women and

WHEREAS it is anticipated that a certain number of married nurses will give up nursing when the regulations come into effect, in part due to the resentment expressed by their husbands, whose income tax will be altered:

Be it resolved, That the Executive Committee of the Canadian Nurses' Association communicate by telegram with the Minister of Finance urging that the application of the new regulation be deferred for one year because of the serious shortage of nursing

service at the present time.

5. Be it resolved, That the Canadian Nurses' Association write the Canadian Red Cross Society expressing our thanks for the gift just given to establish a demonstration Nursing School.

Notes du Secrétariat de l'A. I. C.

L'ORGANISME INTERNATIONAL DE SANTÉ

Les renseignements suivants sont le résumé d'un article paru dans le Bulletin du Conseil International des Infirmières en novembre 1946:

La nécessité pour le Conseil International des Infirmières de coopérer avec l'Organisme International de Santé de même qu'avec l'organisme d'éducation, de science, et de culture des Nations Unis fut demontrée lors de la dernière réunion du Conseil. Mlle Schwarzenberg a rencontré les docteurs A. Stamper et G. B. Chisholm, respectivement président et secrétaire de l'Organisme International de Santé et une demande leur fut adressée pour déterminer de quelle façon nous pourrions le mieux coopérer.

Les vingt-deux fonctions de l'O.I. de S. nous donnent une bonne idée des buts que se propose cet organisme. Mme E. Wickenden, conseillère des E.U. et déléguée de son pays à l'O.I. de S., nous donne ces fonctions:

- D'agir comme autorité directrice et coordinatrice dans le travair international de santé.
- D'établir et de maintenir une collaboration efficace entre les Nations Unies, les associations spécialisées, les Ministères de la Santé, les groupes professionnels et autres corps, si on le juge à propos,
- D'aider les gouvernements sur demande à renforcer les services de santé.
- A fournir l'assistance technique appropriée, en cas d'urgence, l'aide nécessaire sur demande ou acceptation des gouvernements.
- De munir de service de santé ou aider à le faire les Nations Unis qui en feront la demande.
- D'établir et maintenir des services administratifs et techniques nécessaires tel que service d'épidémologie et de statistiques.
 - 7. De stimuler et faire progresser les

travaux qui ont pour but de faire disparaître les maladies épidémiques et endémiques et toutes autres maladies.

- 8. De promouvoir, en coopération avec d'autres associations au besoin, la prévention des accidents.
- 9. De promouvoir, en coopération avec d'autres organismes spécialisés si nécessaire, l'amélioration de la nutrition, de l'habitation, de la salubrité publique, de la récréation, des conditions économiques et de travail et de tous les autres facteurs ayant une répercussion sur la santé.
- De promouvoir la coopération entre les groupes professionnels et scientifiques qui travaillent aux progrès de la santé.
- 11. De proposer des conventions, des ententes et des règlements, de faire des recommendations concernant les questions internationales de santé et accomplir les devoirs que l'O.I. de S. peut-être appeler à remplir et qui sont de son ressort.
- 12. De promouvoir le bien-être et la santé des mères et des ensants et de développer l'habilité à s'adapter harmonieusement dans un milieu nouveau.
- 13. De développer des activités dans le domaine de l'hygiène mentale, spécialement celles qui concernent les relations humaines.
- 14. De promouvoir et diriger des recherches concernant la santé.
- 15. De promouvoir et d'améliorer les normes de l'enseignement théorique et pratique de la santé chez les médecins et chez les autres professions connexes.
- 16. D'étudier et faire rapport, en coopération avec d'autres groupes si nécessaire, des techniques administratives et sociales ayant une répercussion sur la santé publique et aussi sur les soins donnés aux malades, tant au point de vue curatif que préventif, les services hospitaliers et de protection sociale.

- 17. De donner des renseignements, des directives et de l'aide dans les questions de santé.
- 18. D'aider à former chez le public une opinion bien éclairée sur toutes les questions de santé.
- 19. D'établir et reviser, aussi souvent que nécessaire, une nomenclature internationale des maladies, des causes de décès, et des règles d'hygiène publique.
- 20. D'uniformiser les moyens de diagnostique, au besoin.
- 21. De développer, d'établir, et de promouvoir les normes internationales concernant les comestibles, les produits biologiques, pharmaceutiques et autres produits semblables.
- 22. En général de faire tout ce qui est nécessaire pour atteindre le but de l'organisme. VISITE DE LA SECRÉTAIRE-GÉNÉRALE DE

l'A.I.C. aux Hôpitaux de Grande-Bretagne

La Grande-Bretagne, comme dans bien d'autres pays, il y a de la confusion dans le monde des infirmières. Il y a pénurie d'infirmières, les hôpitaux débordent de patients, les services de santé se développent partout. Lorsque la nouvelle loi du service de santé sera appliquée, le besoin d'infirmières sera si grand qu'il sera impossible de répondre à la demande.

Le Ministre de la Santé désespéré a pris la chose en main et en homme pratique a formé un comité qui a pour fonction d'analyser les problèmes du nursing et de faire des recommendations pour remédier à la situation aussitôt que possible. Malheureusement, lorsque nous avons rencontré l'officier médical en chef du Ministère de la Santé, l'on nous informa que le rapport présenté par le comité chargé de cette étude serait confidentiel, tout de même bien des renseignements nous furent donnés que l'on nous pria de garder secrets.

Le Ministère de la Santé organisa un comité de direction pour commencer l'étude de la situation du nursing en Grande-Bretagne. Les personnes suivantes formèrent ce comité: Sir Robert Wood, Ministre de l'Instruction Publique, qui est le président de ce comité, des représentants du Ministère de la Santé, des Pensions, du Travail, et de la Commission du Contrôle (cette dernière est chargée de l'hospitalisation des aliénés et de la régie de leurs biens).

L'étude est présentement faite par un petit comité nommé bureau du travail et est composé de deux infirmières femmes capables et d'expérience, d'un médecin et d'un directeur, le docteur Cohen, qui est à la fois un économiste et un psychologiste. Le bureau du travail a été très actif à faire des enquêtes, à analyser ces dernières afin de faire un rapport au comité de direction. Voici comment l'on procéda dans cette étude:

- 1. En examinant tous les rapports précédamment faits sur le nursing tel que: (a) Lancet Commission; (b) interdepartmental report; (c) Horder et Rushcliffe; (d) rapport sur la médecine sociale; (e) réorganisation du nursing par G. V. Carter.
- 2. Par l'analyse: (a) De cause de départs des étudiantes infirmières; (b) programme de recrutement des infirmières et des aides; organisation de la profession; (c) instruction à l'admission à l'école d'infirmières; (d) méthodes de formation professionnelle; (e) organisation du personnel dans les hôpitaux et les institutions; (f) comparaison des programmes des divers pays.

Le docteur Cohen a commencé un programme d'épreuves en orientation professionnelle pour les étudiantes et il fait aussi une enquête sur les causes des départs des étudiantes infirmières. Cette perte d'étudiantes est alarmante: elle est annuellement de 60 pour cent dans les hôpitaux de Grande-Bretagne. (Au Canada la perte de candidates, le nombre de candidates quittant annuellement nos écoles, était en 1944 de 1,200 soit 12 pour cent.)

Cette étude s'étend de l'année 1937-45 et comprend l'étude d'un rapport fait sur chacune des étudiantes inscrites dans les écoles chaque année. Ces rapports sont classifiés dans l'ordre suivant: (a) Nombre d'élèves quittant l'école avant d'aller auprès des malades; (b) celles qui quittent après avoir été dans les salles; (c) celles qui quittent durant la seconde et troisième année de leur cours ou encore quittent l'hôpital après leur graduation et le chiffre total pour chaque hôpital.

Les causes de départs sont la maladie, le mariage, échecs des examens, renvoi par l'hôpital, démission et raison de la démission, et causes diverses. Il y a eu autant que possible d'entrevues avec les étudiantes qui ont quitté leur cours pour l'une des raisons déjà citées et des renseignements très importants ont été obtenus.

Un psychologiste fait un travail d'analyse étendu aidé d'une infirmière expérimentée qui lui interprête la situation. L'analyse comprend: (a) Le travail de l'infirmière; (b) la durée de temps passé à l'accomplissement des travaux (durée définie pour chaque tâche); (c) chacune des actions faites pour accomplir un travail. Une tentative est faite pour voir si les travaux accomplis sont en rapport de l'enseignement reçu à date par l'infirmière et aussi pour juger si ces travaux correspondent aux aptitudes que l'on juge nécessaire à une infirmière.

Le psychologiste tente d'établir les qualités nécessaires de la personnalité pour suivre avec succès un cours d'infirmière. Il tentera ensuite d'analyser ces qualités dans divers milieux relativement aux milieux hospitaliers. Les hôpitaux choisis pour cette analyse représentent aussi bien les hôpitaux généraux que spécialisés. Voici comment l'on a procédé: Entretien avec la directrice de l'hôpital qui donne les informations générales concernant l'hôpital et son organisation. Chaque salle d'un service différent est visitée dans un entretien avec l'hospitalière de la salle, le programme de l'étude lui est expliqué, et on lui demande des renseignements. L'hospitalière décrit en détail les devoirs de chaque personne de la salle. L'on observe les étudiantes faisant leur travail. Le psychologiste comprend les connaisances scientifiques requises et l'habilité nécessaire pour accomplir ce travail déterminé.

Il est intéressant de noter que le psychologiste a remarqué les facilités matérielles de travail de chaque hôpital et il ne faut pas long à se rendre compte des causes qui contrairement rendent le travail difficile. L'une de ces causes est souvent la mauvaise disposition des salles, fautes qui n'ont pas été corrigées sur les plans. Le psychologiste lors de ses visites fit un plan de chaque salle, sa disposition en rapport de chaque salle d'utilité. Le psychologiste a critiqué vivement d'une part les risques qui découlent de la mauvaise disposition des salles et d'autre part leur répercussion sur le travail du personnel hospitalier et sur les soins à donner aux malades.

Le rapport du bureau du travail doit être prêt pour présentation au Ministère de la Santé le 31 décembre 1946. Ce qui doit arriver après celà est attendu avec beaucoup d'intérêt.

Préparation des Aides: Madame Bennett, officier en chef du Nursing au Ministère du Travail, avait organiser une visite à l'Hôpital de Chelmsford et à l'Hôpital Ste-Marguerite d'Epping dans le comté d'Essex. A Chelmsford, l'hôpital est pour les malades chroniques,

les aides sont envoyées à cet hôpital après leur cours préliminaire au centre d'entraînement. A Epping, l'aide est recue comme assistante de l'infirmière et passe un mois à cet hôpital. Durant ce temps elle recoit un enseignement théorique et elle apprend aussi comment administrer une salle, à faire les lits, à donner un bain au lit, les soins du malade au lit, à prendre la température, le pouls et la respiration. J'ai assisté à un de ces cours donné par une institutrice, infirmière d'expérience, l'enseignement, très élémentaire, se faisait lentement et d'une facon simple. Il v avait douze élèves par classe, la plupart venaient d'Irlande étaient rayonnantes de santé. Elles venaient de milieux très différents et leur dégré d'instruction variait grandement.

Un comité, formé de directrices, reçoit la jeune fille qui désire suivre un cours d'aide. Si l'on constate que l'aspirante a une instruction au-dessus de la moyenne et a les qualités requises pour une infirmière, on lui conseille d'entrer dans une école d'infirmière. On lui dit aussi qu'après deux ans d'étude comme aide elle peut-être admise dans une école d'infirmière. Si la candidate a déjà une partie de ses études comme infirmière, l'on en tient compte lors de son entraînement et cette expérience peut aussi remplacée les études primaires jugées insuffisantes.

Il n'y a pas suffisamment de candidates pour ces cours d'aides. Cet état de chose s'explique par les raisons suivantes:

Selon l'échelle de salaire Rushcliffe, les salaires des aides et des domestiques sont à peu près les mêmes. Durant leurs cours les aides reçoivent £55 ou \$220 la première année et £65 ou \$260 la deuxième année. Si elles sont envoyées dans un sanatorium de tuberculeux, elles recoivent £65 la première année et £75 la deuxième année. entraînement terminé, elles reçoivent £95 avec augmentation de £5 tous les deux ans jusqu'à un maximum de £160. Il faut travailler vingt-deux ans pour obtenir ce maximum de salaire. L'attitude du groupe professionnel qui est définitivement une attitude de supériorité vis-à-vis le groupe des aides est aussi une cause de réssentiment.

Après avoir observé la qualité et la durée de l'enseignement du programme et des expériences faites à date dans l'entraînement de l'aide et aussi d'après les discussions que j'ai eu avec les directrices et les institutrices, je suis de l'opinion que le cours qui est présentement donnée en Grande-Bretagne est à peu près le même que celui qui est donné aux aides (practical nurse) au Canada durant une période de neuf à douze mois.

Formation de l'Infirmière Enregistrée: Des visites furent faites aux hôpitaux suivants: The London, St. Thomas, Westminster, et Kings College Hospital et les hôpitaux satellites qu'ils administrent, grâce à la courtoisie de Dame Katherine Watt, Ministre de la Santé, qui fit les démarchés nécessaires.

Mlle Lawson, déléguée de l'officier en charge du nursing au Ministère de la Santé, m'accompagna lors de quelques unes de ces visites. A ma visite au London, j'ai observé l'enseignement fait en classe et l'enseignement clinique. J'ai passé une journée entière a observé ce qui est appelé "une journée d'étude." Cette journée d'étude fut introduite dans le cours par le London Hospital en août 1945 dans le but d'épargner à l'élève une trop grande fatigue résultant de l'enseignement qu'elles recoivent qui est à la fois théorique et pratique dans les salles de malades. La journée d'étude consiste à assister à des conférences données par des médecins et qui sont suivies de classe sur le nursing.

Durant onze semaines, l'élève reçoit des cours à l'école préliminaire. Ces cours sont suivis de trois périodes d'étude, espacés à différents intervalles, durant les trois années du cours. Durant ces périodes d'étude, l'élève a chaque semaine sa journée d'étude. Durant ces trois années de cours, l'élève a chaque semaine sa journée d'étude. Durant ces trois années de cours, l'élève assiste à cinquante-trois journées d'étude, soit seize journées chaque année plus quatre jours avant les examens d'enregistrement et une journée à l'entrée pour visiter l'hôpital.

La période préliminaire de onze semaines d'étude comprend 202 heures d'enseignement théorique et pratique en science et nursing, plus trente-une heures de culture physique, cinquante heures d'enseignement ménager et jardinage, et quatre-vingt-huit heures d'étude privée.

Il y a quatre cours préliminaires de donnée chaque année, de janvier à mars, avril à juin, juillet à septembre, et octobre à décembre. Le nombre des élèves varie entre quarante à quarante-cinq. Chaque élève, durant son cours, reçoit 351 heures d'enseignement

théorique et de démonstration. Si l'on compare ce programme d'étude au programme proposé aux écoles d'infirmières du Canada ou a celui des Etats-Unis, celà semble très peu. Mais l'on doit se rappeler qu'en plus de celà un nombre considérable d'heures d'enseignement clinique est actuellement donné dans les salles par l'hospitalière. La majorité de ces hospitalières et surveillantes ont plus d'expérience que les infirmières occupant les mêmes charges dans nos hôpitaux du Canada. Je suis allée dans plusieures salles le matin à l'heure des traitements et la qualité des soins donné peut se comparer avec avantage avec ceux que j'ai observé dans plusieurs hôpitaux canadiens et américains.

A la suite de ces observations, de conférences avec les directrices, les institutrices, et les hospitalières voici mes impressions: Les hôpitaux volontaires (ne recevant aucun subsides de l'Etat) en Grande-Bretagne s'efforcent d'ajouter au programme plus d'étude théorique comme nous l'avons fait dans notre pays. Toute fois, l'opinion est (je crois que nous ne pouvons nier le bien fondé de cette opinion) qu'il est impossible pour des élèves qui ont un grand nombre d'heures de service à faire à l'hôpital de bénéficier d'un programme d'étude théorique plus considérable.

Si d'une part j'ai fait ces observations sur les infirmières de Grande-Bretagne d'autre part plusieures directrices anglaises (matrons), qui travaillèrent soit dans l'armée soit dans UNRRA avec des infirmières canadiennes et américaines, firent les observations suivantes: Que nos infirmières semblent très bien préparées pour l'hygiène publique. L'on a remarqué particulièrement celles qui firent leur cours dans "Collegiate Schools" (cours qui aux E.U. correspond à notre cours universitaire de cinq ans); elles démontrèrent une habilité remarquable pour organiser et rendre à bonne fin un programme d'hygiène publique.

Le temps que j'avais à ma disposition étant limité j'ai du renoncer à faire plusieurs visites.

Malgré celà, l'expérience acquisc durant les quatre semaines que j'ai passé à observer (chaque jour était très chargée) m'est déjà utile et j'en suis certaine l'avenir prouvera que ce fut du temps bien employé.

Safety Hint

Keep all medicines and cleaning substances in secure containers, out of reach of young children, plainly marked as to content, and preferably in locked cabinets.

Ward Hypodermic Tray

CATHERINE H. CRAWFORD

THE CENTRAL SUPPLY ROOM at the Royal Victoria Hospital, Montreal, has developed an arrangement for supplying sterile equipment for the giving of hypodermics which, while not unique, has proven very satisfactory. There is a marked saving of time and equipment—both precious commodities in a busy hospital.

The hypodermic set-up includes the

following:

1. A sterile hypodermic set, consisting of a medicine glass in which are: one 2 cc. syringe, plunger and barrel separate, one No. 25, 5/8" needle, and two gauze sponges. These have been done up in a double cotton cover and autoclayed.

2. A ward hypodermic tray containing hypodermic sets; a bottle of sterile water, plain glass of 100 ml. capacity, fitted with a rubber stopper covering the lip; a bottle of denatured alcohol; a glass holding sterile tissue forceps in alcohol; a jar of sterile sponges; a file for opening ampules; an alcohol lamp with spoon for use if boiling water is necessary to dissolve the drug, e.g., pantopon tablet; matches; an enamel dish.

The wards' responsibilities may be outlined as follows:

1. Each ward comes for a supply of sterile sets in a special basket every morning. This may be exchanged for a fresh supply at any time. Unless there are very heavy demands, replenishment is seldom necessary until late afternoon or evening. Slackness on one ward covers the extra demand from another ward.

2. The sets are kept in a wooden basket on the ward. The basket has a central partition running lengthwise. Sterile sets are kept on one side, unsterile on the other, both sides being labelled to prevent any error. The ward is responsible for: (a) keeping the count to twelve sets; (b) returning the basket to the central supply room when all sets have been used; (c) returning breakages for replacement.

3. The bottle of sterile water is

changed each day.

The central supply room is responsible for the maintenance of the equipment. Their procedures are as follows:



Tray and opened syringe package



Syringe basket showing partition

1. The hypodermic sets are dismantled. The syringes are checked for mismated parts; breakages are replaced.

2. Glassware is washed in hot soapy water, rinsed in plain hot water.

- 3. Needles are cleaned with water and ether. They are checked for barbs and damaged needles are sharpened in the hospital instrument department.
- 4. The separate parts of the syringe, barrel and plunger are each wrapped in a single sponge. The needle is also embedded in a sponge. These pieces are packed into the medicine glass, wrapped and loosely packed in large wire-mesh baskets for autoclaving.

The central supply room sends the equipment to be sterilized. Hypodermic sets are autoclaved twice daily. more often if necessary, loosely packed in wire baskets. No solution can be autoclaved in a bottle with a fitted stopper as the pressure will blow the stopper out. To overcome this difficulty, the bottle is filled with tap water and the fitted rubber stopper is loosely held in place by a cloth cap covering the complete neck of the bottle. After they have been sterilized and before they are issued, the cloth cap is removed and the rubber stopper is inserted into the bottle neck and fitted over the lip without contamination.

Obituaries

Mary Isabel Howes, a graduate of the Toronto General Hospital, died recently in Walkerton, Ont., in her eighty-first year.

Kathleen M. Knight, a graduate of the Montreal General Hospital, died recently in Vancouver in her fifty-ninth year. Miss Knight served with the Laval Unit of the C.A.M.C. during World War I. She was invalided home after three years' service and spent the two following years in recuperation. For some time she had charge of the x-ray department at M.G.H. Later she engaged in social service work in Montreal and Vancouver until ill health compelled her to retire in 1944. Miss Knight had a bright, kindly, sympathetic nature and was beloved by her many friends.

Mary Pearl Lumby, who graduated from the Sarnia General Hospital, died recently in Bowmanville, Ont. Following post-graduate study at the University of Western Ontario and in the United States, Miss Lumby served on the staffs of several hospitals. 'She was superintendent of the Cochrane hospital for seven years, transferring to Bowmanville in 1941. In 1943 she accepted the post of superintendent of the Niagara Falls General Hospital, returning two years later to Bowmanville. Her devotion to her work and her friendly personality won her many friends wherever she went.

Margaret Florence McKeown, a graduate of Grace Hospital, Toronto, died recently

in Toronto. For twenty-six years she had served as welfare nurse with the Canadian Pacific Express Co.

Jean Grant (Brodie) Murray, who was born in Tarlair, Scotland, and graduated from the Royal Infirmary, Dundee, in 1910, died suddenly on November 27, 1946, in Toronto. Mrs. Murray had been industrial nurse with the Maclean Hunter News Weekly since 1930.

Nellie Maud (Gadsby) Parnall, oldest living graduate of the Mack Training School for Nurses, St. Catharines, Ont., died recently at the age of seventy-six. Last spring, Mrs. Parnall was honored at a dinner on the occasion of the fittieth anniversary of her graduation. She had been president of her alumnae association for many years and was one of the organizers of the graduate nurses' association.

Doris Selley, a graduate of Wellesley Hospital, Toronto, died recently from injuries received in a motor accident.

Reverend Sister Mary Martha, for over twenty-five years on the staff of the Pembroke General Hospital, died on December 2, 1946. Prior to going to Pembroke she had served at the Ottawa General Hospital.

Enid Wilkins, who graduated from the Portage la Prairie Hospital in 1944, died recently from injuries received in a fall. Miss Wilkins had nursed in Portage, Winnipeg, and Deer Lodge before going as company nurse to Island Falls, Man., last June.

STUDENT NURSES PAGE

Tetanus

JACQUELINE THOMSON

Student Nurse

The General and Marine Hospital, Owen Sound, Ontario.

MR. W, A WELL-BUILT MAN, twenty-five years of age, was admitted on a medical ward of our hospital. This was his first admission to hospital, and his first major illness. He was born in Canada, of Irish parents, and had lived on a farm at some distance from our city most of his life. He had become the sole support of his family which included a crippled father, his mother, and a deaf brother. Though facing difficult circumstances, the family was highly esteemed in the community and Mr. W was regarded as a serious young man who worked hard and long to pay bills promptly and to care for his family.

On the day of his admission to hospital Mr. W had gone to work in his fields as usual. During the morning he had developed a stiff neck and lower jaw. This complaint became increasingly severe and by noon he was unable to sit upright on the seat of his machine. He stopped work, walked with difficulty to his car, and drove to the nearest village to seek medical aid. Dr. M, after a brief examination, decided that his patient was a very sick young man and brought him to the hospital for immediate treatment. He made a tentative diagnosis of tetanus or "lockjaw."

Although of swarthy complexion our patient's color was now dusky and mottled, his brows were elevated and wrinkled, and the corners of his mouth were drawn upwards in a peculiar grin. This facial expression, known as "risus sardonicus," caused by contraction of the muscle fibres, particularly those of the masseter muscles of the jaw, is a common manifestation of tetanus. Respirations were rapid and shallow, and the pulse rate accelerated. The temperature, taken by rectum, was 102.4 degrees.

After preliminary sensitivity tests. Mr. W was given 15,000 units of tetanus antitoxin by Dr. M immediately on his admission to hospital. This serum is prepared from the blood of horses which have been immunized against the toxins of tetanus bacilli. Because of the foreign proteins contained in it, some patients suffer from anaphylaxis, or serum-sickness, when tetanus antitoxin is administered. Fortunately, Mr. W did not show sensitivity to the serum. To confirm his diagnosis, Dr. M performed a lumbar puncture, and spinal fluid was sent to the laboratory for determinative tests. Reports disclosed that the number of white blood cells per cubic millimeter of fluid was elevated above normal. Globulin was slightly increased. Cultures did not produce any pathological organisms. These findings substantiated the physician's diagnosis. To supply fluid to the feverish and perspiring patient, iso-

Vol. 43, No. 2

tonic saline solution was administered intravenously, 1000 cc. every four hours. Into the saline, 5,000 units of tetanus antitoxin was injected. To further combat the infecting organism, 50,000 units of penicillin was given intramuscularly, followed by 30,000 units every three hours. Paraldehyde, drams IV, was administered by rectum, as considered necessary, to induce sleep and lessen muscular activity. By the same channel, sodium amytal, grains VI, given every eight hours, held the muscular paroxysms in check.

During the evening, Mr. W's condition became more serious. His temperature soared to 104° and his pulse became rapid, weak, and thready. The abdomen was rigidly retracted, and the skeletal muscles contracted until the arched body rested on the heels and head only, in the manifestation known as opisthotonos. Respirations were labored, and frothy fluid oozed from between his tightly clenched teeth. Perspiration was profuse. Since delirium was present, severe muscular paroxysms occurred as the patient tossed restlessly.

Constant nursing care was necessary and, because of the restlessness, the physician performed a "cut-down" on the patient's ankle to administer parenteral fluids and the combative medication. Tepid sponging, using long gentle strokes to avoid inducing muscular spasms, reduced the fever slightly during the night. By means of a small catheter attached to a suction-machine, phlegm and mucus were removed from the patient's throat. During the early morning, the bladder became distended and catheterization was necessary.

During the second and third day of his illness, Mr. W showed a very slight improvement although his temperature reached 105.6° and hovered at that point for several days following. Sodium luminal was now substituted for the sodium amytal as sedation, five grains being given by mouth every eight hours. Fifty thousand units of tetanus antitoxin was administered intramuscularly every twenty-four hours, in addition

to the 20,000 units which was now being given with the intravenous fluid every six hours. A severe convulsion occurred on the fourth day and was brought under control, after forty-five minutes of violent twitching, by use of sodium pentothal which is ordinarily used as an anesthetic.

During the next few days, glucose and saline administrations were given continuously by intravenous channels. Soap-suds enemata were given daily to cleanse the lower bowel. On the seventh day there was a definite improvement. Mr. W responded and although he was not well oriented at first, he reacted quite normally by evening. Coughing became a troublesome symptom but the patient, holding himself rigid to prevent musclespasm, was able to expectorate copious amounts of frothy, purulent phlegm. A duodenal tube was carefully inserted and a specially vitaminized formula was given every four hours to provide nourishment. This was utilized without any distress and on the following day the formula was given every two hours. Sedation was discontinued gradually, but the intravenous fluid was continued until the tenth day, by which time the patient was markedly improved. All rigidity had disappeared and the temperature was only slightly elevated in the afternoon. The antitoxin and penicillin were now gradually discontinued.

Although considered a debatable point by some authorities, Mr. W was cared for during the first ten days as a strictly isolated patient. He could give no history of a skin wound when initially examined and had no abrasions or skin lesions. The site of invasion by the tetanus bacillus remained unknown but, since Mr. W pursued farming as an occupation, the possibility of having ingested the deadly spores existed. Although he was in good physical condition generally, Mr. W's mouth and teeth were in extremely bad condition. Dental caries had almost completely destroyed the molars, and the incisors were broken and decayed. The gums were red and spongy and bled readily

while oral hygiene was being carried out. Constant nursing attention was necessary, day and night, and it was deemed advisable to guard against any possibility of cross-infection by the institution of careful isolation technique by the three nurses assigned to the case. Equipment used in the patient's room was carefully wrapped and autoclaved for one hour so that both spores and vegetative forms of the bacilli would be destroyed.

Watchful, gentle bedside nursing was of the utmost importance during the first two weeks of Mr. W's illness. The room was kept darkened, warm, well-ventilated and free from drafts. At night, lamps were carefully shaded. Noise was controlled in the adjacent rooms and corridor. Mindful of the extreme hyperesthesia present in such cases, and that the slightest touch, jar, or noise might precipitate tonic spasm, accompanied by excruciating pain, nursing care was carried out as gently as possible. Bed-clothing of light weight was used and supported by body cradles. During convulsions mild restraint was exercised so that the patient might not injure himself. A wooden tongue depressor, padded with bandage, prevented tongue damage at such times as were necessary. The back, heels, and elbows were rubbed gently with alcohol and cocoa butter to aid circulation and improve skin tone. Small, soft pillows of various sizes supported and protected the body. Mouth care was difficult to carry out because of the rigidity of the jaws. Cotton-tipped applicators soaked in peroxide were used to cleanse the teeth and gums, and a mixture of glycerin and lemon juice aided in cleansing the tongue and preventing the formation of crusts and sordes. Close observation of the condition of the patient's pulse, respiration, color, and skin was necessary so that any reaction from the large doses of antitoxin and penicillin would be noted immediately. Fluid intake and output were likewise carefully measured so that edema or urinary suppression might be guarded against. Valuable nursing experience was gained through preparing for, and

assisting, the physician with lumbar puncture and venepuncture, as well as in maintaining a continuous flow of parenteral fluid. The constant intramuscular injections gave rise to many painful sites and the patient was made more comfortable by gentle massage over these areas. By varying the site of injection each time, a small measure of pain was prevented.

Mr. W's recovery was hastened by his willingness in carrying out any advice which would speed his discharge from hospital. He was anxious to resume the delayed spring work on his farm and, by inquiring of the friends who called, we were able to tell our patient that kindly neighbors had rallied and were helping out during his absence. This information greatly relieved Mr. W's mind, and during his convalescence he appeared to quite enjoy the rest and nourishing food. Although naturally somewhat shy and reserved, he was interested in hearing about the nature of his illness. Being a farmer he knew that "lockjaw" often appeared among cattle and horses but had neither seen the disease among his own livestock, nor in the section in which he lived. We were able to tell him that the tetanus bacillus is normally found in the intestinal tract of herbivorous animals and is transmitted to the soil by means of their excreta. Here, faced with an unfavorable environment, the bacillus forms spores and is able to survive for many years without oxygen. Because of this phenomenon, hay, grass, straw, and soil may prove to be the origin of a case of tetanus. It was evident that Mr. W would be able to do some local health teaching on his discharge from hospital by relaying to other farmers the information that the practice of chewing hav or straw could be exceedingly dangerous, and also that abrasions, especially puncture wounds, which were contaminated by soil or animal excreta, could result in "lockjaw." He was much impressed when he learned that a small dose of tetanus antitoxin, administered early, provides reliable prophylaxis against the disease. Attention was drawn to

Mr. W's teeth and he was urged to see a dentist as soon as possible even though removal of all his teeth would likely be suggested. The importance of good oral hygiene was pointed out and we felt quite sure that Mr. W would act upon the advice he had received.

When discharged from hospital, three weeks from the date of his admission, Mr. W seemed to bear no evidence of his serious illness. He had regained his lost weight, his color was healthy and, except for his decayed teeth, he was considered to be in excellent physical condition when examined by his physician. He

remained shy and reticent throughout his convalescence and, although his expressions of gratitude on his discharge were tendered with rather youthful awkwardness, we knew that our patient was sincerely appreciative. We, as nurses, felt amply rewarded since, for all of us, it was a new experience. This had been the first established case of tetanus to be admitted to our hospital in some time, and we were deeply grateful to Dr. M for his patience in answering our numerous questions. Because of our lack of experience with this disease we had depended upon his instruction and guidance throughout the case.

Book Reviews

Effective Living, by C. E. Turner, A.M., Ed.M., Sc.D. and Elizabeth McHose, B.S., M.A. 432 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1, 2nd Ed. 1945. Illustrated. Price \$2.50.

Designed to meet the needs of students in high school classes for a reliable text in their courses in health or hygiene, the subject matter of this book is on a sufficiently high level to make it useful as the text for courses in this topic given to the preliminary students in our schools of nursing. With probationers coming into the school from widely distributed centres, it is inevitable that there should be a marked difference in the basic health instruction each has received during her schooling. Some will have had a sound introduction to the whole field of personal and community health. Others have only the most sketchy information on many of the topics. Since student nurses have such limitless opportunities for health teaching, both by personal example and by actual conversation, it is essential that they should early receive a thorough grounding in factual information. This text would fill that purpose admirably.

The authors have divided their material into three parts: effective living for the individual, in the family, and in the community. Each part is subdivided into units, fifteen in all. Several of these latter are broken down

still further. Where limited time is a factor, the instructor could combine or eliminate such units as seemed advisable.

The text is well illustrated both by photographs and line drawings. Each unit closes with a series of problems and activities designed to stimulate further interest in the students.

Body Mechanics in Nursing Arts, by Bernice Fash, B.P.E., B.S. 130 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18. 1946. Illustrated. Price (in U.S.A.) \$2.75.

Reviewed by Winnifred MacLean, Assistant Superintendent of Nurses, Royal Victoria Hospital, Montreal.

All who have to do with the process of developing the student into a skilled and efficient nurse will study this book with interest and enjoyment. The illustrations are excellent.

The first section is devoted to tests, well illustrated, which prove the principles underlying good body mechanics. These principles are listed with examples of nursing procedures in which they may be applied. For instance, Experiment No. 2 deals with the flexors and abductors of the arms:

"Principles: (1) Keep the parts of the body as close to the vertical axis of the body as possible. (2) Stand close. (3) Use the largest,

strongest muscle groups and the greatest number of muscles.

"Examples:

- 1. Bed bath: Have the patient at the near side of the bed to prevent reaching.
- 2. Bedmaking: When mitering linen, loosening bed linen, and tucking, stand as close to the bed as possible so that the arms may remain close to the body. When folding linen hold it so that it may be brought as close to the vertical axis of the body as possible.
- 3. Tray carrying: When carrying a tray by grasping along the top edge, holding it with the thumbs up, the strain is placed on two small muscles: the flexors and extensors carpi radialis. When carrying it by holding it on the palms, the load is divided among more muscles. The strain is placed on the flexors profundus sublimis digitorum and palmaris, in addition to the two small muscles, the flexors carpi radialis and ulnaris; thus there is less load on each muscle because more muscles are put to work."

The student is asked to list in her notebook other examples to which the principles are applicable. One can readily realize how the nurse's energy and time can be conserved and muscle strain lessened. All of this will benefit the patient by increasing her comfort and peace of mind, because the nurse knows how to move her skilfully, almost effortlessly, i.e., getting the helpless patient into a wheel chair.

Lastly, the nurse's posture will be improved. She will have learned to carry herself with head up, shoulders back and body erect. For, even in the simple procedure of taking a pulse, she has learned, "Frequent distortions result from holding the watch too low and too close to the body, so that stooping is required in order for the second hand to be within range of vision."

Medical Services by Government, by Bernhard J. Stern, Ph.D. 208 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) \$1.50.

Reviewed by Dorothy Tate, Director, Public Health Nursing, Provincial Board of Health, British Columbia.

Bernhard J. Stern, Ph.D., through his concise account, traces the responsibilities assumed by local, state, and federal governments. In including the scope, trends, and

nature of medical services provided by governments, he presents information which will influence future developments. The changing emphasis of medical services, demonstrated by specific experiences, further impresses one with government's increased acceptance of its role in providing medical services, directly or indirectly.

Dr. Stern's description of historic and contemporary activities provides a stimulus to our thinking of the future position of government in medical services. It is a source of information from which an evaluation may be made for the future program of adequate medical care for the people. The subject material is of vital importance and is presented in a logical and interesting manner.

Medical Education and the Changing Order, by Raymond B. Allen, M.D., Ph.D. 142 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) \$1.50.

Reviewed by Hazel Keeler, Director of Nursing Education, University of Manitoba.

In this monograph, the author reviews the present educational preparation of medical doctors in the light of the adjustment aim of education. Dr. Allen points out the weaknesses in present-day medical training and suggests ways and means of overcoming these inadequacies. He says that in order to produce successful doctors it is necessary first to attract, by wise counselling, into the medical schools the above-average and gifted students from the secondary schools. Within the medical school Dr. Allen advocates a broadening of the curriculum to include the social sciences and the humanities. He emphasizes that it takes a man, not a machine, to understand a man.

He urges that every effort be made to provide opportunity within the various courses for the student to learn the scientific method of thinking and how to apply the experimental method in the testing of hypotheses of his own devising.

Much of what Dr. Allen says about the inadequacies of present-day medical training applies just as well to the preparation of other professional workers and to the preparation of nurses in particular. Anyone interested in the preparation of the professional worker will find this monograph interesting and stimulating.

Moose Jaw:

Dr. G. Kinncard, regional medical health officer, was the speaker at a regular meeting of Moose Jaw Chapter. Formerly medical health officer with the British Colonial Service, he described the various countries in which he had worked and related amusing incidents which occurred during his twenty

years' service.

E. Thorburn and A. Hyer are now on the staff of the Saskatchewan Department of Public Health, Miss Thorburn being at

Melfort and Miss Hyer at Assiniboia.

PRINCE ALBERT:

A whist drive, sponsored by the sanatorium staff, realized \$12 for the Cod Liver Oil Fund. Mrs. Halpin gave an interesting book review on "Climate Makes the Man."

SASKATOON:

St. Paul's Hospital:

At a recent meeting of St. Paul's Hospital Alumnae Association, Mrs. Gould, society editor of the Saskatoon Star Phoenix, gave

an informal talk on "Publicity."

A successful tea was held by the alumnae association during the holiday season. association during the holiday season. The many patrons of this enjoyable function were received by Miss M. Robinson and Mmes R. Anderson and J. Robertson, while registrars were Mrs. J. Wood, M. Schwinghammer and S. Ritchie. Presiding at the tea table were Mmes L. Atwell, H. Nordstrum, B. Sallans, L. McConnell, C. Thompson, and Miss M. O'Hara, while the Mmes M. Rogers, H. Motram, L. Haywood, R. Streeter, M. Barker, Misses S. Ritchie and P. Snell were hostesses. The sewing booth was well patron-Barker, Misses S. Ritchie and P. Sneil were hostesses. The sewing booth was well patronized and in charge of Mmes W. Briggs, A. Cary, C. Darbellay, N. Smith, and G. Cowell, while at the cooking table were Mmes P. Willms, J. Shelley, Misses L. Lenz, F. Lawley, L. Defaye, M. Henriette, W. Smith, E. Cooper, and E. Worobetz. Mrs. J. S. Miller was the winner of the door prize. was the winner of the door prize.

THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1947 Spring examinations for provincial

The 1947 Spring examinations for provincial registration will cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the licence to practise will write in Montreal, Quebec, and Sherbrooks on April 9, 10, and 11, 1947.

GROUP B: Students who will have completed their first year before March 1, 1947, will enter the preliminary test covering oral, practical and written, which will be held on March 10, 11, 12, and 13, 1947.

(Time to be automorated in each school.)

(Time to be announced in each school.)

For application forms and all information relating to the examinations apply to the headquarters of the Association.

Applications for preliminaries must be received by February 28, 1947, and for finals by March 30, 1947.

E. FRANCES UPTON, R.N., Secretary-Registrar 506 Medical Arts Bldg., Montreal 25, P.O.



of the Future

Keep them healthy—let Baby's Own Tablets help you. Pleasant, simple tablet triturates, they can be safely depended upon for relief of constipation, upset stomach, teething fevers and other minor ailments of babyhood. Warranted free of narcotics and opiates. A standby of nurses and mothers for over 40 years.

BABY'S OWN Tablets



THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler and Jean M. White. This book is divided into 10 units—a well-planned series, leading gradually to the more intricate medical and surgical nursing skills. Each chapter has questions, demonstrations, subjects for discussion, guides for review. Twelfth printing. 793 pages, 145 illustrations. 1946. \$4.00. 793 pages,

SURGICAL NURSING

By Robert K. Felter and Frances West. Here is a text that has been one of the most popular in the subject for many years. Fourth edition. 589 pages, 252 illustrations, 7 colour plates. 1946. \$4.00.

> THE RYERSON PRESS TORONTO

Positions Vacant

Instructor. Ward Head Nurses. General Staff Nurses. Applications are invited from nurses eligible for ticensing in the Province of Quebec. In first letter state date of graduation, qualifications, experience, and when services would be available. Apply to Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

Nursery Supervisor: \$105 per month. Ward Supervisor: \$110 per month. Operating-Room Scrub Nurse: \$100 per month. General Duty Nurses: \$100 per month. All stated salaries include full maintenance. 200-bed General Hospital in Niagara Peninsula. Apply to Supt., County General Hospital, Welland, Ont.

Classroom Instructress immediately for 125-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., General & Marine Hospital, Owen Sound, Ont.

Dietitian, preferably with some experience, for 125-bed hospital. Salary: \$130 per month plus maintenance. Apply in care of Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Dietitian and Graduate Staff Duty Nurses (3) for 165-bed hospital. Administrator. Bassinets. Good salaries. 8-hour day and 6-day week. Apply to Mother M. Immaculata, St. Michael's General Hospital, Lethbridge, Alta.

Graduate Nurses (2) immediately for 32-bed hospital. 8-hour day and 48-hour week. Salary: \$38.10 per week, less \$1.00 per day for board. Apply to Lady Supt., Anson General Hospital, Iroquois Falls, Ont.

Graduate Nurses for General Staff Duty at Muskoka Hospital (for Tuberculosis). Salary: \$145 monthly for 1st year; \$150 for 2nd year; \$155 for 3rd year—\$30 deducted monthly for full maintenance. Yearly vacation. Cumulative sick leave. Pension Plan. Apply to Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Obstetrical Supervisor with post-graduate experience for 100-bed hospital with Training School. Apply to Supt., General Hospital, Cornwall, Ont.

Assistant Superintendent. State qualifications and salary expected. General Duty Nurses. 6-day week. Hospitalization Plan. Salary: \$100 per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg. P.Q.

Operating-Room Nurse for Chest Surgery. Eligible for British Columbia registration. Day duty only. 8-hour day; 5½-day week. Gross salary: \$125 with increments up to 7th year. Uniforms and laundry provided. 1 month vacation each year with pay. Superannuation. Sick leave with pay, up to 2 weeks for major illness and 6 days for minor illness, accumulative. Live out. Apply, stating qualifications and experience, to Supt. of Nurses, Vancouver Unit, Division of Tuberculosis Control, 2647 Willow St., Vancouver, B.C.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: \$125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Registered Nurses (2) for General Duty. Straight 8-hour shift; 44-hour week —5½ day week. Gross salary: \$126.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

General Duty Nurses for 44-bed, fully modern hospital. Salary: \$100 per month plus full maintenance. Separate nurses' home. 8-hour day and 6-day week. 3 weeks' holiday with pay after a year's service. Apply to Supt. of Nurses, Municipal Hospital, Grande Prairie, Alta.

Registered Nurses for General Duty at the Toronto Hospital for the Treatment of Tuberculosis, near Weston, Ontario. 8-hour day and 6-day week. Gross salary (straight 8 hours): \$150 per month for the 1st year; \$155 the 2nd year; \$160 the 3rd. For broken hours: \$155 per month for the first year; \$160 the 2nd year; \$165 the 3rd. One day's sick leave with pay per month, accumulative. 3 weeks' vacation per year, with pay. Generous Pension Plan. Apply to Supt. of Nurses.

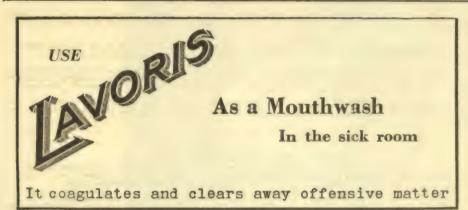
158 Vol. 43, No. 2

WANTED — ASSISTANT SUPERINTENDENT OF NURSES

A Graduate Nurse is required for the above position at the Manitoba School for Mentally Defective Persons, Portage la Prairie, Manitoba. Applicant should have had some Mental Hospital experience, and should be capable of teaching in the School of Nursing attached to this hospital.

Starting salary: \$135 per month, PLUS FULL MAINTENANCE—accommodation, meals, laundry, etc. This is a permanent position offering one month's vacation with pay annually, sick leave with pay, pension privileges, etc. For full particulars, apply immediately to:

MANITOBA CIVIL SERVICE COMMISSION 223 Legislative Building, Winnipeg



Floor Duty Nurse. 6-day week. Salary: \$100 per month; full maintenance and free hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Duty Nurses. Salary: \$95 per month with full maintenance. Attractive, homey residence recently opened. 1 month's night duty during each 6 months of duty and 2 weeks' holiday with pay for every 6 months of duty. For further particulars apply to Dorothy I. Mac-Rae, Supt. of Nurses, Herbert Reddy Memorial Hospital, 4039 Tupper St., Westmount, Montreal 6, P.Q.

Registered Nurses for Tuberculosis Hospital. Salary: \$1.35 per month and meals. 6-day week. Apply to Supt. of Nurses, Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18, P.Q.

Supervisor of Home Nursing Classes. Must be qualified to later assume direction of Red Cross Home Nursing and Reserve Dept. Applications are invited from Graduate Nurses with Public Health training or experience and executive ability. Apply to Chairman, Home Nursing Dept., Hamilton Branch, Canadian Red Cross Society.

Official Directory

THE CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Committee on Institu-tional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing,

Alberta: (1) Miss B. A. Beattie, Provincial Mental Hospital, Ponoka; (2) Miss A. M. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss E. I. Stewart, Health District, High River; (4) Mrs. B. Kipp, Galt Hospital, Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5, 1334 Nicola St., Vancouver.

Manitoba: (1) Miss B. Seeman, Winnipeg General Hospital; (2) Mrs. H. Copeland, Misericordia Hospital, Winnipeg; (3) Miss D. Dick, 145 Montrose St., Winnipeg; (4) Miss Jean McPhail, 859 Bannatyne Ave., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie. St. Joseph's Hospital, Saint John; (3) Miss Lois Smith, Walker Apts., York St., Fredericton; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton.

Nova Scotia: (1) Miss L. Grady, Halifax Infirmary; (2) Sr. M. Beatrice, Glace Bay; (3) Miss M. Shore, V.O.N., Halifax; (4) Miss M. Stevens, Box 345, Amherst.

Ontario: (1) Miss N. D. Fidler, School of Nursing, University of Toronto, Toronto 5; (2) Miss E. Young, Ottawa Civic Hospital; (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs., Toronto 2; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. Mary Irene, Charlottetown Hospital; (3) Miss E. Wheler, Summerside; (4) Miss M. Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre. Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25; (3) Miss A. Girard, l'Ecole d'Infirmières Hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 3533 University St., Montreal 2.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss N. Lambert, 341-12th St. W., Prince Albert; (3) Miss E. Smith, Dept. of Public Health, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q. Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans Affairs, Ottawa, Ont. Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man. Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta. Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont. Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

EXECUTIVE OFFICERS

International Council of Nurses: 1819 Broadway, New York City 23, U.S.A. Executive Secretary, Miss Anna Schwarzenberg.

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall.

Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Asa'n of Registered Nursee: Miss E. Bell Rogers, St. Stephen's College, Edmonton.
Registered Nurses' Asa'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
Manitoba Ass'n of Registered Nursee: Miss Laura Fair, 214 Balmoral St., Winnipeg.
New Brunswick Ass'n of Registered Nursee: Miss Alma F. Law. 29 Wellington Row, Saint John.
Registered Nursee' Ass'n of Nova Scotia: (Acting) Miss Nancy Watson, 301 Barrington St., Halifax.
Registered Nursee Ass'n of Ontario: Miss Mailda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.
Prince Edward Island Registered Nursee Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlotte-

Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25, Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Vol. 43, No. 2 160

VOLUME 43 NUMBER 3 MONTREAL MARCH 1947

CANADIAN NURSE



 Nutrition in a Public Health Program in Canada
 by E. W. McHenry

New Methods of Treatment for Venereal Disease —Syphilis

by B. D. B. Layton



Maple Sugar Bush

National Film Board Photo





When you say "USEFUL" hands, LISP!

KEEPING useful hands youthful is a problem, and nowhere is this truer than in the nursing profession. Passive, useless hands require a minimum of care. Active hands need active measures.

Counteract the innumerable washings necessary in any hospital and keep your hands soft, white and attractive by using 'Wellcome' BRAND Toilet Lanoline daily. Massaged gently into the hands every night and, used more sparingly, in the morning after washing, this soft, soothing cream will supplement the natural oils of the skin and give "on duty" hands that "off duty" look.

Tubes of two sizes at all reliable pharmacies.

'WELLCOME'

Toilet Lanoline



BURROUGHS WELLCOME & CO.

(The Wellcome Foundation Ltd.)
MONTREAL

For a generous free sample simply mail this card to P.O. Box 159, Montreal.

Please	send	me	a	free	sample	of	Wellcome	BRAND
Toilet	Land	ine						

Name.

Address



... the renewable fabric finish that resists dirt ... soil and ... moisture!

Uniforms stay crisper, cleaner-looking longer . . . wash more easily . . . when they are protected with Johnson's DRAX! And both these advantages mean a cutting down of laundering costs!

DRAX... made by the makers of Johnson's Wax... is an amazing new, *invisible* fabric finish that gives each thread of the fabric the wonderful protection of wax. Dirt slides off, water and liquids wipe easily away... because dirt is not ground into the fabric it washes easier, cleaner without fabric-fatiguing rubbing and scrubbing.

DRAX is grand for curtains, tablecloths, place mats and other washable things, too. It saves so much time in the washing . . . so much wear . . . and keeps things looking cleaner longer, it's well worth looking into. Find out about DRAX today!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

MARCH, 1947

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

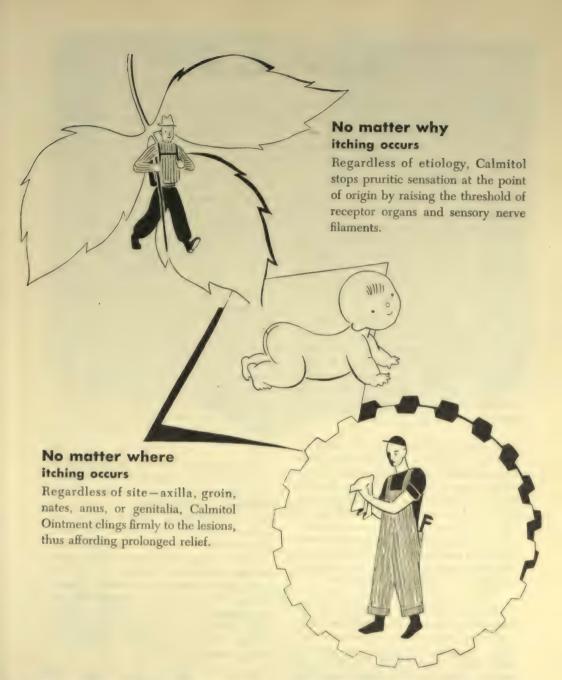
CONTENTS FOR MARCH, 1947

Progress in Saskatchewan	$\dots D$.	Harrison	177
Nutrition in a Public Health Program	E. W.	McHenry	179
New Methods of Treatment for Venereal Disease — Syphilis B. D. B	. Lay	ton, M.D	. 182
Hospital Housekeeping	E. A.	. Pearston	187
Bedside Nursing — An Essential Service	. E. I	M. Rowles	190
The Late Cancer Case	S. You	ing, M.D.	195
A Rare Opportunity			197
Plans for Visitors from I.C.N. Congress			198
The Use of Volunteers	ind S.	MacKay	199
Our Own Page	E. So	humacher	201
Le Registre Ville-Marie	A	M. Robert	203
Notes from National Office			205
Notes du Secrétariat de l'A.I.C.			
Interesting People			212
Educational Policy			215
Nursing in China	L. (C. Preston	2,17
An Answer to Evelyn			219
A Home-Made Incubator	M	. Cochran	220
Book Reviews			221
News Notes			226
Official Directory.			239

Subscription Rate: \$2.00 per year — \$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.O.

Vol. 43, No. 3



CALMITOL

The Leeming Miles Go. Lid.
I NOTRE DAME ST. W., MONTREAL I, CANADA

No matter how much or how often

Regardless of extent or frequency of use, Calmitol is safe. It does not contain harmful phenol or cocaine. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate, will not be absorbed systemically.

MARCH, 1947

Reader's Guide

It is many months since we have welcomed the president of one of our provincial associations as guest editor. We are happy to present Mrs. Dorothy B. (Cotton) Harrison, president, Saskatchewan Registered Nurses' Association, in this issue.

Mrs. Harrison graduated in 1937 from the Montreal General Hospital. After postgraduate experience at the Toronto Psychiatric Hospital, she joined the staff of the Montreal branch of the Victorian Order of Nurses. In 1939, she received her certificate in public health nursing from the McGill School for Graduate Nurses and returned to the Order staff. After seventeen months in charge of the branch at Westbank, B.C., Mrs. Harrison was transferred to the Saskatoon branch. Eighteen months later, shortly after her marriage, she retired from active duty. Aside from her association responsibilities, Mrs. Harrison is very much engrossed in adapting all of her learning and experience to the education she is receiving at the hands of her small son.

It will be our good fortune during the next three or four months to be able to share with our readers the excellent series of articles being prepared for us by faculty members of the Department of Public Health Nutrition, University of Toronto. Commencing the series, we present the broad, comprehensive picture of the important role nutrition should play in the present-day public health program from the capable pen of Dr. E. W. McHenry, professor and head of the Department.

Deaths attributed to syphilis in the 1945 prelimininary annual vital statisties report totalled a relatively small number-740when compared with such gross killers as heart disease and cancer. However, the total of damage done by syphilis cannot be measured in terms of the number of deaths. Congenital syphilis, to take just one illustration, results in malformed and mentally deficient children by the score. Be sure to read what Dr. B. D. B. Layton has to say regarding the value of penicillin administration in the prevention of this malady. Dr. Layton is chief of the Division of Venereal Disease Control, Department of National Health and Welfare, Ottawa.

The winner of the first prize in the 1946 article contest sponsored by the Journal, was C. E. M. Rowles, industrial nurse with the Dominion Glass Co. Ltd., Redcliff, Alta. Her thoughtful presentation of the importance of bedside nursing is well worth reading more than once. Today, there are echoes of dissatisfaction among nurses that they do not have sufficient time to do a thorough job in giving actual nursing care to their patients. When there is a tendency to skimp on this service, read this article again. Miss Rowles has some convincing arguments.

Did you have to help with the cleaning and dusting on Saturday mornings at home when you would much rather have been out-of-doors playing? If you did, hospital house-keeping possibly does not hold very great problems for you. Still, you will profit from the sound advice which Elizabeth Pearston offers on this subject. Miss Pearston has had a wealth of experience in managing hospitals. She is the busy superintendent of nurses at the Fort Qu'Appelle Sanatorium, Fort San, Sask.

We are glad that it was decided to continue the former Section pages when the constitutional changes were made last year. Helen McArthur is chairman of the Committee on Public Health Nursing. Sheila MacKay was secretary at the time this report was made. Miss McArthur is director of Nursing Services for the Canadian Red Cross Society. Miss MacKay is assistant director, Division of Public Health Nursing of the Alberta Department of Public Health. Marguerite E. Schumacher is chairman of the Publicity Committee in the Committee on Institutional Nursing. She is superintendent of nurses at Grace Hospital, Winnipeg.

Preview

One of our most precious faculties, our eyes, will be the subject of the article to be featured next month. The author, Dr. Charles A. Thompson, of London, Ont., will describe the special care that should be given to prevent injury and infection of the eyes, with special emphasis on the responsibilities of the industrial nurse in this connection.



Tubex *

PENICILLIN IN OIL AND WAX (ROMANSKY FORMULA)

Now available in the safe, convenient container for injection with the Tubex syringe

- · Most cases of gonorrhea are cleared up by a single injection.
- Pneumococcal, streptococcal and staphylococcal injections usually respond to one or two Tubex per day.
- Therapeutic blood levels are maintained in most patients for twenty-four hours.

The Tubex assembly combines convenience with safety

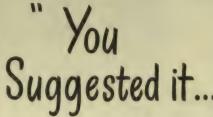
. . . By exerting negative pressure (withdrawal) it is easy
to make certain that a blood vessel has not been entered
prior to injection.

Packages of 6 Tubes (1.cc. size) with Tubes syrings and 6 Tubes needles. Each Tubes contains a single-dose of 300,000 international units of dried penicillin calcium in pasants oil with 4.8 % becassas. Single Tubes with needle are available. Directions with each package.

*Trade Mark Reg. in Canada

JOHN WYETH & BROTHER (CANADA) LIMITED . WALKERVILLE, ONTARIO

MARCH, 1947





are proud of your confidence. In compounding
Baby's Own Toiletries, our primary
objective was to develop the gentlest, most soothing
toiletries for a baby's extra sensitive skin. But we had
another aim, and that was to deserve your
recommendation.

You can rest assured we will continue making toiletries worthy of your confidence as long as babies need soap, oil and powder made especially for them.



The J. B. WILLIAMS CO. (CANADA) LIMITED

La Salle, Montreal



The other factors are important, too

The superior results obtained from natural vitamin B-complex therapy, are due to the combined effect of many components, some well known and others as yet unidentified.

The increasing preference for natural vitamin B-complex therapy parallels the growing concept that B-vitamin deficiencies are usually multiple.

B-PLEX Wyeth is an aqueous extract of rice bran—one of nature's richest sources of the B-Complex—Biologically Balanced¹ by the addition of crystalline B Factors. B-PLEX supplies thiamine hydrochloride, riboflavin and niacin in the ratio of 1:2:10² PLUS adequate amounts of pyridoxine, pantothenate acid PLUS the unidentified factors naturally present in rice bran extract.

¹The evaluation of Preparations of the vitamin B-Complex. C.M.A.J. May, 1942,

³ Council on Pharmacy and Chemistry and Council on Foods and Nutrition. J.A.M.A. 119-12-948.

Trade Mark Reg. in Canada

MARCH, 1947



SOUPS

Beef and Liver Soup Tomato Soup Vegetable Soup

MEATS

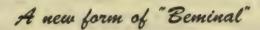
Chicken, Vegetables
and Farina
Vegetables with Lamb

VEGETABLES

Asparagus Carrots
Green Beans Peas
Beets Spinach
Peas and Carrots
Squash and Carrots

DESSERTS

Applesauce
Apple, Prune
Custard Dessert
Apricots with Oatmeal
Peaches
Pears with Farina
Prunes
Plums with Farina
Orange Custard Dessert
Peach Custard Dessert



"BEMINAL" FORTE

INJECTABLE

(DRIED)

No. 495

This product provides, when reconstituted, a high concentration of important B factors for intensive therapy. The dried form permits the preparation of solutions of varying concentrations and protects the potency of the material for an indefinite period.

Each vial is standardized to contain:

Thiamin Chloride	300	mg.
Riboflavin	30	mg.
Niacinamide	700	mg.
Pyridoxine	50	mg.
Calcium d-Pantothenate	50	mg.



AYERST, McKENNA & HARRISON LIMITED

Biological and Pharmaceutical Chemists

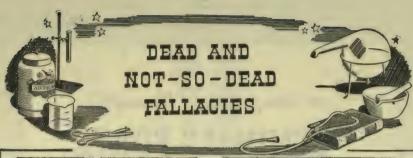
MONTREAL

agetal

454

MARCH, 1947

CANADA





Pregnant stones, or "pietre gravide," were once considered by Italian peasants as an indispensable aid to normal childbirth.

The stones were worn for nine months. After the birth the stones were passed along to another prospective mother.



Some people still believe that canned foods must be cooked.

This, of course, is not so—for in the canning process, foods are cooked thoroughly.

Canned foods need only to be heated and seasoned.



A M E R I C A N C A N C O M P A N Y MONTREAL HAMILTON TORONTO VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

—a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

CANNED FOOD IS GRAND FOOD

AMERICAN CAN COMPANY
Medical Arts Building, Hamilton, Ont.
Please send me the new Canadian edition of "THE CANNED FOOD
REFERENCE MANUAL," which is free.
Name

City.....Province.....





here's why...

Trushay's beforehand protection offers preventive action before hands are damaged. Before washing hands, apply Trushay. An invisible film is formed over skin tissues, which helps guard against the harsh effect of washings and cleansing agents. Trushay applied beforehand is widely used by professional men and women to aid in replacing natural oils and help keep dermal tissue soft and pliable. Trushay, the beforehand lotion, is well adapted to the needs of the physician, dentist and nurse.

TRUSHAY



The Beforehand Lotion

Product of Bristol-Myers Company of Canada Ltd. 3035 St. Antoine Street, Montreal 30, Que.

FINGER ON THE PULSE:

No pets allowed: At San Pedro, California, three members of Canadian steamer Ranger each took aboard a pet. On arrival at Panama they were relieved of their mascots—three girl friends.

Wouldn't hear of it: Romano Pandolfi of Rome got fed up with jokes about his long ears. With a razor he pared them down to more conventional size. Romano lost some ear, a lot of blood, but still hears.

Just in time: In good health and spirits, Mrs. Louise Klemme of Chicago visited Undertaker Alfred Dumroese and talked about her funeral arrangements. A few minutes later, en route home by trolley, she collapsed and died.

Grandma's night out: About 30 grandmas, ranging in age from 60 to 90, recently staged a merry gettogether in Brooklyn where, amongst others, Mrs. Josephine Berman, a 70-year-old great-grandmother cut some fancy capers. Josie Berman started dancing 5 years ago and can jitterbug, rhumba and samba.



"You know, I AM beginning to feel bester."

They look to you, Doctor..

"The destruction of bacteria (disinfection) or interference with

their activities (antisepsis) by chemical means is attempted daily in

proceedings ranging between proved usefulness and utter futility."

Garrod, L.P. and Keynes, Geoffrey L. (1937) Brit. Med. J. 2, 1233.

I should have been addressed to the medical profession itself, how much more does the unskilled user of antiseptics—the ordinary householder—stand in need of guidance!

ALL ANTIBACTERIAL agents — whether for treatment or prevention — are in some degree selective. The choice of the antibiotic or chemotherapeutic substance for treating an established infection is a matter for your skill. But the choice of the antiseptic for preventive use in the home is a matter which calls clearly for your advice.

FOR GENERAL USE in unskilled hands, obviously the less selective agent is to be preferred.

Now, it is one of the many advantages of 'Dettol' that it is rapidly lethal to a diversity of common pathogenic organisms; to haemolytic streptococci, to Strep.pyogenes, Staph.aureus, B.coli,

B.typhosum and to such wound contaminants as B.proteus and Ps.-pyocyanea. And for all this low selectivity, 'Dettol' is non-toxic, highly bactericidal in the presence of blood, pus and other wound debris, pleasant in smell and non-staining to linen or the skin.

its high germicidal efficiency, safety and pleasantness have won preference for 'Dettol' in all the leading maternity hospitals of Canada. The value of such a non-poisonous antiseptic for prompt unsupervised use in households (where there may be young children) needs no emphasis.

'DETTOL' OBSTETRIC CREAM is a preparation of 30 per cent. 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against reintection by haemolytic streptococci.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL



MARCH, 1947

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gyneco-logical Nursing.

For further information apply to:

Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. Q.

01

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

One-Year Certificate Courses

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses 1266 Pine Ave. W.

McGILL UNIVERSITY, MONTREAL 25

UNIVERSITY OF MANITOBA

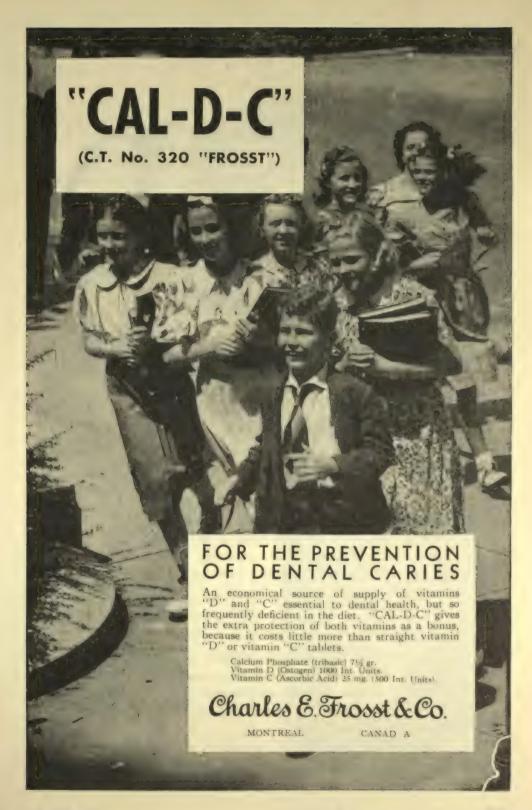
Post-Graduate Courses for Nurses

The following one-year certificate courses are offered in:

- 1. PUBLIC HEALTH NURSING
- 2. TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
- 3. ADMINISTRATION IN SCHOOLS OF NURSING

For information apply to:

Director School of Nursing Education University of Manitoba Winnipeg, Man.





My course in skin care taught me about the little blue jar"

Like most student nurses, I had to be taught proper skin care. And the first thing I learned was something scores of nurses have known for years...to use the Medicated Skin Cream, NOXZEMA for such common skin discomforts as rough, red, chapped hands, tired, burning feet and externally-caused skin blemishes.

Then I started using NOXZEMA as a night cream. It's greaseless, stainless, and helps make my skin feel wonderfully soft and smooth.

Now I'm using it as a powder base under make-up -- it helps smooth my complexion just the way it does red rough hands! In fact, NOXZEMA is "a regular beauty course" in a little blue iar!

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER THREE

MONTREAL, MARCH, 1947

enerous concentration contents and contents

Progress in Saskatchewan

In Saskatchewan, as elsewhere in Canada, the past year has been an exceedingly busy one. So many new developments are taking place at a time when we are faced with a shortage of trained personnel. This means that nurses everywhere are straining their resources to meet the rapidly changing needs in the world.

However, while day-to-day business is making great demands on our present staffs, we are all very conscious of an underlying feature which colors all our thinking and is uppermost in our minds while conducting nursing affairs, and this feature is the new trend in nursing education.

A great deal of thought is being given to the question of nurse education and the leaders in the nursing profession are showing us that a great many changes from present-day policies will be necessary, in order to prepare the graduate nurse to meet the demands of nursing service which the future inevitably will bring. Many are stirred with an unrest and a dissatisfaction with

present conditions. Under the guidance of our nursing leaders we are beginning to have a vision of the future, and realize that the future holds great possibilities for the nursing profession. We realize the necessity of sound leadership and careful



DOROTHY HARRISON

planning in order to bring about the

desired changes.

However, in this world one must be practical as well as visionary. We, who are primarily interested in supporting health measures, are faced with problems of inadequate staffs and lack of available finances. We are working with groups who may not see the question of nursing education in the same light as we ourselves see it.

In Saskatchewan, while keeping our future aim before us, since the ending of hostilities our main efforts have been toward stabilization of existing conditions, mainly through trying to assist in developing good working and living conditions for the nurses throughout the province. We realize these are basic to the provision

of good nursing service.

A well-planned brief was submitted some time ago to the Saskatchewan Government on how nurses might fit into a provincial health insurance scheme. Recommendations included those covering salaries, hours of work, living conditions, sick leave, vacation with pay, and a scientific method for determining an adequate More recently a nursing staff. summary of these recommendations has been sent to the Saskatchewan Hospital Association, to all superintendents of hospitals, superintendents of nursing, and to chairmen of hospital boards.

While the recommended salary schedule is somewhat higher than those generally prevailing in the province, authorities have agreed that it is reasonable in the light of present-day conditions and we have good reason to hope that this and others of the recommendations

will gradually come into effect. In conjunction with this, our travelling instructor is visiting all the hospitals in the province to help hospital boards and staff nurses to interpret the recommendations and to meet existing local problems.

Uniform regulations governing monthly allowances, uniforms, breakage and other fees, also the preliminary course, have been agreed upon by authorities in hospitals conducting schools. This is a recent and for-

ward development.

The nurses in Saskatchewan are taking an active part in the province-wide hospitalization scheme which went into effect on January 1, 1947. While for a time it may mean added strain on existing nursing and other personnel, we feel that our Government has done a very fine piece of work toward the eventual establishment of health insurance in this province. Nurses throughout the province are wholeheartedly supporting the plan.

With the rapid development of health insurance in Saskatchewan, the formation of Health Regions entailing an increase in the number of public health nurses employed, and the planning for a University Hospital, there is an increasing de-

mand for nurses.

We, as an association, are making every effort to keep the individual nurse well-informed so that by concerted effort we may find the best means whereby to cope with the demands of the present and the future, a future which promises unlimited opportunity.

DOROTHY HARRISON
President, Saskatchewan Registered
Nurses' Association

Coming Event

Event: Annual Meeting of the Registered Nurses' Association of Nova Scotia.

Date: May 29 and 30, 1947.

Place: Halifax, N.S.

Nutrition in a Public Health Program

E. W. MCHENRY

FTER THE RECOGNITION of bacteria as causative agents for many diseases, the prevention and treatment of infectious diseases became the centre of public health activities. Water supplies, the pasteurization of milk, disposal of sewage, and immunization were the main concerns of health officers. As a result there were great advances in public Smallpox, typhoid fever, diphtheria, and other infectious diseases have become rare in Canada. This phase of activity is not yet complete; the safeguarding of milk by pasteurization is not yet universal in Canada.

Old cemeteries contain numerous tombstones which give eloquent testimony to progress in the field of When we see evidence of health. the deaths of many children under six years of age we realize what has been accomplished. Whole families are not wiped out today by diphtheria. If children can be raised now to adult life, we should be concerned with what else can be done to give them the health which they should have. Control of infectious diseases is still. and always will be, essential. modern health program should include activities which will ensure as healthy a life as is possible. The abolition of slums, the prevention of malnutrition, facilities outdoor for exercise, adequate illumination to prevent eye-strain, and other aspects of a healthy environment should be given attention.

Should nutrition be included in a public health program? Most public health officials in Canada would give an affirmative answer, but very few would be prepared to implement the answer. A widespread attitude would be: acute deficiency states are extremely rare in Canada, so let's not get excited. It is hardly necessary to point out that there is clear-cut evidence that adequate nutrition dur-

ing pregnancy is essential for the health of mother and child, that adequate nutrition is necessary for proper growth and health of children, and that optimal use of food is highly advisable for adults. Nutrition is one of a number of factors which control health. As such it cannot be ignored in a program designed to improve the level of health in Canada.

A word of caution regarding nutrition is advisable. During the past few years there has been considerable enthusiasm for nutrition and many nutritionists have given a distorted impression to the public. Nutrition is not the *only* environmental factor influencing health and a properly designed program includes all factors. It is unwise to be concerned with the feeding of a child without giving thought to protecting the child against infection. We have seen children who could not chew a nutritious meal because of the bad condition of their teeth. The kind of health program needed in Canada is one in which all factors influencing health are given proper emphasis. Undue attention to any one aspect, whether it be nutrition, housing, or the control of venereal disease, is unwise because the disproportionate enthusiasm ignores other essential constituents of a sound

health program.

Many health officers dismiss nutrition from their health programs because they erroneously believe that there are no nutrition problems in Canada. They consider that rickets is now under control, that there is little scurvy, and that other deficiency diseases do not occur. Hence why bother? There is definite evidence to prove that this attitude is wrong! It is based on a lack of knowledge.

Recent studies by Dr. Sylvestre in Quebec, by Dr. Webb and Miss Swan in New Brunswick, by our de-

partment in Ontario, and in British Columbia and Saskatchewan by Dr. Pett and his staff have all shown that the nutrition of children is not satisfactory. It is unlikely that Canadian children are not receiving sufficient food to satisfy appetite, but it is clear that the kinds of foods are not those which should be chosen for health. recent study of school children in the Toronto area showed that 30 per cent were securing less milk than is needed to ensure an optimal supply of calcium. In recent studies 9-11 per cent of the children had evidence of having had rickets. Most of these studies have indicated that school children who need vitamin D for normal growth of bone were obtaining inadequate amounts. The nutrition of many Canadian children is not yet optimal for health.

In most of Canada iodine deficiency and consequent goitre are still problems, and problems which need not exist. Consider only one province—Ontario. Information has not been available since 1925 regarding the amount of endemic goitre in Ontario. It is known that iodized salt, the only dependable source of iodine available, is used by about one-half of the population. The use of iodized salt was compulsory in all army and air force establishments in Canada during most of the war. The same protection should be given to the general population.

The general attitude toward very stout people is one of amusement, and it is considered impolite to say or do anything to remedy the situation. Insurance statistics and several scientific studies have clearly proven that overweight, even in moderation, is harmful in middle-aged and older persons. Overweight lessens life expectancy and causes undue strain on the heart, liver, and kidneys. Overweight is due to a consumption of food in excess of requirements and should be regarded as an undesirable nutritional abnormality capable of correction and prevention. If a health department is concerned with the health and life-span of people under its care, it should be actively interested in the prevention of obesity. Data regarding the incidence of obesity in Canada are not available but casual visual inspection indicates that there is some.

All recent surveys have shown that the condition of teeth in Canadians is far from satisfactory. The cause or causes of dental caries cannot be stated with certainty. It is probable that a number of factors are involved and that nutrition is important. It is believed that dental health depends upon adequate intakes of calcium, phosphorus, and vitamin D. It is also believed that generous supplies of sugar as such or sweet foods like candy, cakes and soft drinks, are harmful. One of the fortunate results of war restrictions has been a decrease in the consumption of sugar. So far as Canadian children are concerned it is still much too great. Under war conditions in Britain there has been a marked improvement in children's teeth. The same improvement could be attained in Canada by changes in eating habits.

There are nutrition problems in Canada and the correction and prevention of these should be matters of concern to public health officials. Suitable preventive measures cannot be undertaken unless the causes are ascertained. Is there enough of the right kinds of food available in Canada to meet nutritional needs? far as the country as a whole is concerned, the answer is ves. Government statistics show that a sufficient quantity of various foods is available to satisfy the needs of the whole population, provided these foods are distributed and used according to need. Such distribution and use are not the practice at present. There may be sufficient milk in some districts and insufficient supplies in other sections. Foods supplying vitamin C may be adequate in cities in the late spring and scarce in remote rural sections. It may often be true that food importation is not the need but rather the better utilization of local supplies. may seem strange to say that food

supplies should be of interest to a medical officer of health. What is the use of urging an increased use of milk if the needed milk is not available?

Considerable attention is given to the economic cause of malnutrition. It is frequently said that some families are financially unable to buy healthful foods in proper amounts. This factor does operate and was serious during the depression years of 1932-7. It has been much less important in the past few years and is rendered less serious by family allowances. A misleading statement is often made—that a given percentage of families have incomes of less than \$1,200 a year and, consequently, must be undernourished. The figure generally quoted includes families in villages and small towns where an income of \$1,200 may be equivalent in purchasing power to \$2,400 in Montreal or Toronto. However. another aspect of low income urban families is often overlooked. may be sufficient money to purchase food but inadequate cooking equipment may prevent the preparation of suitable meals. It is not possible for a mother, however intelligent, to prepare good meals for her family if all she has is a two-burner gas-plate, a tea-kettle, and a few saucepans. Poor housing and inadequate kitchens may cause malnutrition.

The principle causes of malnutrition in Canada, whether that malnutrition be obesity or deficiency, are ignorance and indifference and, of these, the latter is the more A great many avenues of education are available and are utilized surprisingly little. people just don't care. This attitude. or lack of attitude, is not confined to nutrition; it is true of most aspects of a health program and also true of many other affairs. A lot of people are indifferent about voting and about anything which would cause apparently unnecessary exertion. This indifference has to be overcome before health education can function.

It is unnecessary and, indeed, unwise to attempt nutrition education apart from a general program of education in healthful living. The best place to start such a program is in prenatal care and a direct, selfish appeal may be the most effective. If a pregnant woman has proper care, including an adequate use of food, both she and her baby will be better. Health education should begin in infancy and, so far as nutrition is concerned, it should be the goal of Canadian health programs to have every baby properly fed. Health education, including nutrition. then logically develops through childhood. Health habits are formed and in older children the reasons for these habits are explained.

The most effective transmitter of health education is the public health nurse. No appeal can be as valuable as the personal one which the visiting nurse makes to the mother and to the family. All pathways of education, radio, newspapers, pamphlets, are insignificant in comparison to the personal approach. Upon the shoulders of the already over-burdened nurse rests the responsibility for arousing the families to the need for healthful

living.

Bacterial Resistance

The observation of the ability of bacteria to develop resistance to streptomycin after a few days may be of particular importance at this time. The same has been noted in respect to both the sulfa drugs and penicillin, but apparently the phenomenon is more pronounced with streptomycin. In at least one case, test tube experiments showed there was a 100-fold increase of the resistance of an organism in ten days. Given indiscriminately, the drug may lose any value for a particular type of infection in an individual for the rest of his life. Improper use may cause variation and selection in disease agents so that streptomycin is no longer effective for the infection where it is of greatest value at the present time.

-News Notes No. 55

New Methods of Treatment for Venereal Disease—Syphilis

B. D. B. LAYTON, M.D.

OF ALL THE REMARKABLE advances in the treatment of disease which have been noted during the past few years, it is doubtful if any can approximate the progress made in the management of syphilis. Commencing during the past decade with the introduction of intensive and sub-intensive treatment courses employing arsenicals and bismuth, and further accentuated by the relatively recent discovery that penicillin is effective in the treatment of both syphilis and gonorrhea, any feeling of stability in syphilis treatment methods which may have existed

is completely dissipated.

However, with the full appreciation that the latest schedules devised for the treatment of syphilis, especially those including penicillin, are still in the experimental stage, it may be of interest to review in general terms some of the more promising procedures which have been investigated. In this discussion, therefore, an attempt will be made to present some conspicuous points of interest regarding new methods of treatment for syphilis, particularly those coming into prominence during the past few years. It is repeated with emphasis, however, that final appraisal and evaluation of the results must await the passage of time and further extensive trial.

To revert briefly to earlier accepted methods of treatment for comparison with the more modern procedures, various combinations of arsenicals and bismuth have long been employed as the standard antisyphilitic treatment. Weekly injections over prolonged periods, eighteen months as a minimum, totalling at least forty injections of arsenic, usually neoarsphenamine, and forty of bismuth, have been and still are employed for standard treatment.

At intervals, this treatment course was interrupted by the so-called rest period during which little or no medication was administered. This, fortunately, has now been abandoned by the majority of physicians since it is recognized that, in order to be most effective, treatment must be given continuously and without in-

terruption.

The advent of mapharsen, which has been shown to have effective therapeutic action with relatively lower toxicity, permitting twice-weekly injections, resulted in a series of studies aimed principally at the reduction of the time period over which treatment was administered with the maintenance or improvement of the cure rate. Numerous treatment schedules have been investigated and some of those which appear to hold the most promise, designated as intensive and sub-intensive methods, are reviewed briefly.

Experiments with the administration of drugs by a continuous intravenous drip have shown that by this method the toxicity of the drug is greatly reduced and that larger quantities thus can be administered over a shorter period of time. This general principle was first applied in 1933 in the treatment of syphilis by Chargin, Hyman and Leifer. After considerable study these investigators devised the five-day continuous intravenous drip method consisting of the administration of a quantity of mapharsen daily for five consecutive days for a total of 1200 mg. of the drug. This can be given by the slow intravenous drip method over a period of seven to twelve hours or by the rapid intravenous method lasting one to three hours.

The advantage of the five-day intravenous drip is that few patients fail to complete their treatment

course. Its major drawback is the reported high mortality rate of 1:200, and the fact that it is a complicated procedure requiring highly trained personnel and constant supervision. It is usually supplemented by daily bismuth injections accompanying the treatment or a course of bismuth following the intravenous drip.

Another type of intensive schedule, the twenty-day method, consists of the injection of mapharsen, once daily for twenty consecutive days, usually accompanied by bismuth injections every three or four days. The reported mortality rate by this method is 1:350, although later experience indicates it to be considerably lower than this figure. The treatment results appear to be comparable to the five-day intravenous drip. Other procedures involving the injection of mapharsen twice daily for ten days and the administration of thirty single consecutive daily injections have also been investigated.

A less intensive method, the triweekly schedule of mapharsen injections, for eight to twelve weeks, has been recommended by Eagle. When this is supplemented with weekly bismuth injections satisfactory results are observed. The reported fatality rate by this procedure has been 1:1200.

The twenty-six weeks' sub-intensive method combines the advantages of the earlier standard procedure with those of the more intensive rapid courses. The main disadvantage is, as in all prolonged treatment schedules, the delinquency rate, i.e., patients failing to complete an adequate treatment course. It consists of forty spaced injections of mapharsen, given twice weekly throughout the first ten and the last ten weeks of treatment, for a total dosage of approximately 2400 mg. of the drug. Sixteen injections of bismuth subsalicylate are given during the first and final five weeks and the middle six weeks of the treatment schedule.

None of these procedures has been in use sufficiently long to permit complete appraisal and in attempting to sum up the respective merits it should be emphasized that, according to most authorities, short-term intensive arsenotherapy of syphilis is too hazardous for use in general practice. The safer methods of semi-intensive arsenotherapy, such as the Eagle method and the twenty-six weeks' plan, are recommended for general use. Results have been satisfactory with all these methods which may be used on an ambulatory basis.

One approaches the preparation of a commentary on the treatment of syphilis with penicillin with considerable reluctance and the full realization that any statement made, no matter how general, must be subject to revision in the light of new reports and clinical findings constant-

ly coming to attention.

As a result of the experimental and clinical research carried on to date, the following points, according to Stokes, would appear to be fairly well established with regard to the penicillin treatment of syphilis: penicillin is non-toxic; penicillin destroys treponemas; the organisms usually disappear from surface lesions in 12-24 hours when penicillin in adequate doses is administered, frequently sooner; no penicillin-resistant organisms have vet been encountered in man; penicillin follows the old rule — the sooner the treatment is administered in early syphilis the better the results encountered: intramuscular injection is the method of administration; the accepted safe dose is not larger, for the moment, than 2,400,000 Oxford units in eight days; the time interval between doses has considerable elasticity not yet determined; penicillin and mapharsen in combination appear to be effective more so than either drug alone at the same dosage level; experimentation shows that repeated moderate or large doses of penicillin at intervals over a period of time show most effective results in comparison with: (1) a single large dose; (2) repeated large doses at short intervals; and (3) when given in retarding vehicles, i.e., peanut oil and beeswax; treatment can be repeated in case of relapse or recurrence at equal or larger

doses with renewed response in most but not all cases.

Schoch and Alexander supplement these comments with the following recommendations: that the intervals between injections should not exceed three hours, i.e., without employing a retarding vehicle; the total dosage should not be less than 2,400,000 units: the period of treatment should not be less than seven and one-half days: mapharsen and/or bismuth should be used in addition, with preference for the latter since it is less toxic; follow-up observation should extend five years and include quarterly serologic tests and the examination of the cerebrospinal fluid; penicillin failures should be re-treated on an individual plan; in view of the possibility of re-infection all contacts should be sought and, if necessary, treated.

At the moment the only disadvantages associated with the use of penicillin for syphilis appear to be restricted to the fact that under present methods of treatment a period of hospitalization is required and that injections of the drug must be made at relatively frequent intervals, accentuating the factor of discomfort associated with the treatment pro-

cedure.

In general, the results of the numerous research studies carried on to date indicate, according to Moore, that in the treatment of early acquired syphilis of the adult, penicillin alone does not appear to be equal to the older intensive methods of chemotherapy, i.e., arsenic and bismuth. The best results were observed when the duration of the disease was less than two weeks, and a high percentage of failures has occurred when the duration of the disease was two months or more.

These observations are supported by the reported findings of Pillsbury in which the results of treatment of a large series of cases with penicillin are compared with the findings following the twenty-day massive schedule. Follow-up on 792 cases treated by the latter method for six months or more after treatment revealed results (as shown by the accompanying table) which are compared with the findings of a group of penicillin-treated cases according to the stage of the disease in which the diagnosis was made.

From these figures it is observed that penicillin is equal in its effectiveness to the twenty-day procedure in sero-negative primary syphilis but becomes progressively worse in seropositive primary and secondary cases. Pillsbury concludes that penicillin is an effective remedy in early syphilis but that the schedule of treatment may need to be modified for seropositive primary cases as well as those in the secondary stage. He points out that it would be of great advantage if more cases of syphilis could be diagnosed before the blood test becomes positive.

In expressing a general opinion on the penicillin treatment of syphilis, Cole has stated: "The great value of penicillin is that you are able to treat the patient quickly without killing

him. Despite the high rate of treatment failures, the penicillin treatment

of syphilis is here to stay."

Experimentation with the rapid methods of treatment employing penicillin and arsenicals, individually or in combination, has focused attention upon the importance of close follow-up of patients. Adequate surveillance involves the physical examination of the treated individual at relatively frequent intervals for

PERCENTA	PERCENTAGE OF NEGATIVE	
SEROLOGIC TESTS		
After	After	
Penicillin	20-day Therapy	
98.18	98.68	
87.82	95.10	
72.07	92.68	
	SEROL After Penicillin 98.18 87.82	

clinical evidence of recurrence of the infection, and laboratory examination of the blood for serologic relapse. This should be carried out every two to three months in the first year after treatment and at increasing intervals during the second and subsequent years. The cerebrospinal fluid should be examined six months after treatment and again within eighteen to twenty-four months to assure freedom from complications involving the central nervous system.

The seriousness of nervous system involvement by syphilis has directed the attention of research workers studying the effect of penicillin towards the treatment of certain conditions resulting from this complication. As with other types of syphilis, the final assessment of results awaits the passage of time and the accumulation of clinical data. However, it would appear that the value of penicillin in neurosyphilis will at least equal and, in some varieties of the disease, exceed the results obtained by other known forms of therapy.

Investigation has shown that the most striking effects of penicillin are observed on the cerebrospinal fluid. Generally speaking, the drug exerts a beneficial influence which is demonstrated in the progressive reduction towards normal of the abnormal finding in the spinal fluid. This effect is continued over weeks and months after administration, the maximum improvement usually being secured in the first four months.

The quantities of the drug used are considerably greater than those administered in early syphilis, the dosage range being of the magnitude of four to eight million units.

Although a number of studies have been reported, the following summary of one such investigation will serve to illustrate the character of the research being done and the results encountered:

Following treatment of 161 cases of syphilis of the nervous system by a group of prominent clinicians it was concluded that, as measured clinically and by blood and cerebrospinal fluid changes, penicillin is an active thera-

peutic agent in neurosyphilis. The greatest effect on the signs and symptoms occurred in the mental breaks, the inco-ordination, the tremors and speech defects of paresis, and the lightning pains of tabes. Fixed pupils, absent reflexes, and other signs of destructive lesions did not improve.

Spinal fluid abnormalities were particularly responsive to penicillin, the effect upon asymptomatic cases being the greatest and upon paretics (G.P.I.) the least. Blood serologic responses were less than those noted in the cerebrospinal fluid.

By way of a general summary of the effectiveness of penicillin in neurosyphilis, based upon the findings and observations up to this time, the group of investigators concluded that penicillin is the first choice in the treatment of neurosyphilis but with qualification in severe paretics in which failure to improve promptly indicates further treatment with either more penicillin or with fever therapy.

In this study initial doses of 2,400,000 or 4,800,000 units of penicillin were administered. Close and continuous observation was required to detect failure to improve, in which case more penicillin or fever treatment was given. It is interesting to note that tabetics with lightning pains received up to twelve million units and in multiple courses.

Of all the types of syphilis thus far with penicillin the most optimistic results appear in the management of syphilitic pregnant women as demonstrated by the condition of the newborn infant. At two prominent institutions in the United States parallel studies were carried out on a group of 114 pregnant women who delivered a total of 118 babies (four women became pregnant and completed their terms twice during the course of the study with treatment during the first pregnancy only). Of this group, 114 babies were born apparently normal (96.7%), one infant was syphilitic (0.8%), and three of the women aborted (2.5%) at the fourth, sixth, and seventh months.

With regard to the cases which aborted, it should be pointed out that this is considerably lower than the abortion rate in non-syphilitic pregnant women. During this study and subsequently, it has been concluded

that there is no evidence to show that penicillin is instrumental in the production of either actual or threatened abortion and that this need not be seriously considered as a danger in the treatment of syphilitic pregnant

women with the drug.

With regard to the duration of the pregnancy at the time of treatment, from the results observed it is apparent that treatment at practically any stage of the pregnancy is effective in preventing congenital syphilis. The majority of the women received either 1,200,000 or 2,400,000 units of penicillin as a total dosage, given in divided doses every three hours over a period of not less than eight days.

With such an apparently effective treatment method available, further emphasis is placed upon the importance of prenatal examination, including blood-testing. Careful prenatal observation of the pregnant mother, with at least one blood test during her pregnancy, preferably in the early months, should virtually

eliminate congenital syphilis.

Although insufficient time has elapsed for final evaluation to be made, studies thus far carried out seem to indicate that penicillin is the best agent yet developed for the treatment of infants born suffering with syphilis, i.e., infantile congenital syphilis. Immediate clinical improvements are striking, reactions seem unimportant, and in the cases observed over appreciable periods the incidence of clinical and serologic relapse has been relatively small.

In one study which has been reported, penicillin treatment was administered to a group of 191 infants diagnosed as suffering with congenital syphilis. The ages of the patients ranged between eleven days and twenty-three months. A brief summary of the results, after preliminary observation, shows that following treatment serologic relapse alone was noted in 3.6% and clinical plus serologic relapse in 2.6% of the total. Deaths during or after treatment,

amounting to 12.6%, have been largely attributable to causes other than syphilis. The remaining number, approximately 81%, were considered satisfactory, i.e., apparently cured.

An encouraging feature of this treatment procedure is that serologic decline may continue over a long period and the percentage of cases showing a negative blood serologic test increases up to at least eighteen months after treatment. It would thus appear that the results of penicillin treatment in infantile congenital syphilis are exceedingly en-

couraging.

There can be no doubt from the information available, incomplete in many respects as it is to permit the formation of positive conclusions. that penicillin has a definite place in the treatment of syphilis. At this time its value in prenatal and congenital infantile syphilis seems to be very definite, and in neurosyphilis one may hope for an encouraging percentage of optimistic results. early syphilis the results appear most favorably influenced by the early initiation of treatment thus further emphasizing the importance of early diagnosis. However, with all the knowledge which has been gained it would be remiss if one did not reemphasize at this time that the treatment of syphilis with penicillin is still in the experimental stage.

Until such time as the status of penicillin in syphilis is finally determined, standard treatment will consist of the administration of arsenicals and bismuth in recognized treatment schedules. The precise method to be employed in any specific case will, of course, be determined by the physician responsible for treatment but it is felt that the great majority of individuals diagnosed as suffering with syphilis will, for some time to come, benefit most by the administration of these drugs. Under present circumstances this provides the best means of eradicating the syphilis germ and thus assuring the future health and

well-being of the patient.

Hospital Housekeeping

ELIZABETH A. PEARSTON

When one leaves a large city hospital following some years of ward supervision to take over the position of nurse superintendent of a small town hospital—possibly sixty beds—one feels a certain degree of confidence until confronted with the problem of housekeeping.

Housekeeping in the small hospital does not mean advising a qualified housekeeper or a chief steward that corners are being missed, that floors are too highly polished or not polished at all, or that curtains, pillows, etc., need replacing. Oh dear, no!! The nurse superintendent finds that she is the only person expected to control such matters and she has a day or two of panic until she gets certain essentials of housekeeping firmly entrenched in her mind.

The first essential is, of course, to keep the hospital clean and to have the co-operation and interest of those who are actually doing the work. To institute and maintain this, the nurse superintendent herself must know the proper methods to employ. If she has received a good home training in general housekeeping, then she is lucky; however, she may have gleaned certain knowledge of housekeeping during her nursing career, although actually housekeeping is not specially mentioned in the curriculum. A good reference book* on housekeeping will be of immeasurable assistance, especially when quick decisions have to be made, and pending the time, when, possibly, by bitter experience, she has acquired expert knowledge. When one has to learn and teach at the same time, that good old Irish idiom, "Sit tight and keep two jumps ahead," is fun. Further, if the housekeeping staff (usually girls drawn from the district) realizes that the work is important a pride in achievement will be built up. The members of the housekeeping staff enjoy wearing a well-made uniform-type of dress when on duty and it also encourages them to look nice and act well.

A program of duties should be made out for each member of the housekeeping staff, rigid enough to become routine but leaving some hours free each week to take care of the unexpected. There is no spring or fall cleaning in hospitals—clean all the time is essential. Cleaning, polishing, dusting, scrubbing, in the ordinary sense, are done every day. Other duties could be done weekly or monthly, such as transoms polished. blinds and high fixtures dusted, walls brushed down, and so on. people working in one place does not always mean better work. Competition seems to work out better, that is. giving each person one set of duties to complete. If she gets through faster on one day than another, she ought not to be loaded with extra work. Also, a little praise for work well done goes a long way and the pleasure evinced is heartening to all concerned. All personnel in the hospital should be conscious of the efforts put forth by the housekeeping staff. Such incidents as spilled water, powder trailed from an operatingroom floor by stretchers and footfalls should be cut to a minimum: visitors should be asked to remove overshoes before entering wards; in fact, everything possible should be done to avoid untidiness. To avert trouble between the housekeeping staff and the nursing staff, care must be taken to have the housekeeping schedule dovetail into that of the ward schedule. For example, sweeping floors when dressings are being done is, of course, out of the question and would cause friction and delay; meal hours must be avoided when dusting,

^{*}America's Housekeeping Book, compiled by New York Herald Tribune Home Institute, 1945. Publisher: Chas. Scribner & Sons. New York.

etc., has to be done. By making meal-time an event in the day's routine, it is easy to institute a policy that *all* personnel available should take part in the quick and efficient distribution of trays to the patients and similarly in the return of the trays to the pantry. It follows that sweeping, dusting, etc., just automatically stop if all personnel are required for tray service.

Although a straight eight-hour day is advocated, it will be found that, in many instances, housekeeping workers prefer two hours' rest during the afternoon. This rest should not be disturbed. When the staff returns later in the afternoon there are many duties that can be carried out then, such as cleaning of windows, replacing clean curtains, cleaning silver, etc.

Proper equipment for cleaning and proper storage space for such should be provided. Dusters should be of a fast color and even torn linen, only good for dusters, should go through the dye-pot. A good wall-brush and radiator-brush are essentials although not always included in ordinary clean-

ing equipment.

Floors should not be so highly polished as to be dangerous. Baseboards, window-sills, and finger-marks on doors and elsewhere should have daily attention. Proper facilities for the cleaning of toilets, bathtubs, etc., will greatly minimize this unpleasant task. By polishing up the "handle of the big front door" all things pertaining to that entrance have to live up to the brightness of the brass. What is more attractive and inviting to the sick stranger than a well-kept entrance even though the word "welcome" is not on the doormat? The rear door should be as clean as the front door. A nurse superintendent does not waste time if she takes a ten minute stroll around the outside of the building each day, possibly leaving by the front door and re-entering by the back door. She is likely to spot many housekeeping defects, such as sagging screens, ripped blinds, limp curtains and, possibly, the usual debris that an unthinking public might scatter in the vicinity of the building. She

might even find that by having gravel on certain paths or roads, instead of mud, less would be carried into the hospital that later would have to be swept out. A building can very quickly acquire a "run-down" look and seem drab and uninteresting. If, on the first approach, a board of managers does not see the need for painting or alterations, the project should not be lost sight of. It should be remembered that the board has to consider very carefully the expending of public monies but the persistence of a nurse superintendent often brings about the desired result—provided she can show that the necessity really

If a nurse is contemplating changing over to small hospital management, she might get in touch with the purchasing agent of her own hospital. It is no sin to display one's ignorance and the purchasing agent will be glad to advise her of the proper soaps, starch, abrasives, polishes, etc. By having a list of all such items and the reference book mentioned above, she will at least have a basis on which to start. As time passes, when possibly newer or better materials are on the market, she will have had enough experience to make a sound choice.

The laundry is an important part of the hospital and this, too, comes under the supervision of the nurse superintendent. If she finds that the linen is well washed and ironed, she should be content to leave things that way. However, it would be wise to have the procedure tabulated and filed away for future use. If, however, the linen is drab and grey, investigation should be made immediately. The laundry should be watched in operation and several things might be found as reasons for poor washing: faulty sorting of linen, hard water, too heavy loads in the washingmachine, wrongly proportioned ingredients in the washing formula, improper timing, rinsing, or drying. If there is a large institutional laundry in operation within a reasonable distance, it should be recommended that the person in charge of the laundry of the small hospital be sent there

under a master laundry-operator for a week or so. This will pay dividends, not only in the appearance of the linen but in the wear and tear and in the use of laundry supplies. Having had the benefit of expert laundry operation, a proper routine formula should be established. This should be put into readable form, typed, and posted in the laundry, remembering to retain a copy for reference file.

The maintenance of linen is simple if a proper procedure is followed. All torn linen should be kept apart when sorted in the laundry. Stains should be marked before linen goes to the laundry and the cause of the stain noted. If a hospital is not large enough to employ a full-time seamstress, the nurse superintendent definitely should not try to handle repairs herself. If she does attempt to do this, she will be confronted with the torn linen piling up to an astonishing degree in a very short space of time, which will lead to shortages on the wards. Her duties are so manifold and so often urgent, that the repairing of linen seems unimportant in comparison and will be left until a day when there is not so much to attend to. That day never comes! It would be well to find someone in the town (who would be glad of a few hours work each week) to keep torn linen from accumulating. It might also be possible to have one of the laundry workers take over this duty as it then serves a dual purpose by arousing more interest in reducing the quantity of linen being torn in the laundry. A supply of "new" linen should be stored ready for circulation to ensure an adequate supply always being available over holidays or when laundry equipment breaks down. New linen could be issued only to cover the emergency and later returned to stock. All linen should be adequately marked and misuse strictly forbidden. In the small hospital, older linen can be stored in an appointed spot so that it can be quickly put to use when acids or any staining fluid have to be used in the treatment of a patient. Inventory should be taken at least four times a year.

Blankets: Purchasing of blankets

should be done with caution. sample blanket should be obtained and washed several times before making final purchase of a quantity. By having the sheets long enough (108) to 112 inches) to afford a good "turnin" blankets are not as likely to become soiled. They should be aired on the clothes-line for some hours following discharge of a patient and washed when necessary. Enough blankets must be in circulation to allow for this. The methods for blanket-washing should be included in the laundry Protectors for "overinstructions. throw" blankets in use can be made by having the top eighth or quarter encased in an envelope-type of cover made of sheeting.

Pillow-cases should be long enough to come well over the ends of the pillows. The pernicious habit of filling the pillow-cases with soiled linen and throwing them down the chute should be prohibited as the strain greatly reduces the life of the pillow-case. Pillows should be kept free of dust and powder, well beaten, and well aired. If soiled, they can be put through the washing-machine although they take quite a time to

dry, even in the heater.

Mattresses should be well protected, well brushed, well aired. Enough clean mattresses must be on hand to permit this procedure to be carried out. After a mattress has been treated, an ordinary sweeping-broom, kept for the purpose, can be used to give a final brushing, using a 2 per cent Lysol solution. This should be done outside.

Storm and screen windows: As the proper use of these definitely affects the housekeeping, sufficient time should be given when they are to be changed at the proper seasons so that windows may be cleaned, screens brushed off, etc.

Insect pests: Flies may be kept down by various methods. If a hospital is unfortunate enough to be infested with cockroaches there are several kinds of deterrents on the market today and some firms contract to keep pests down by treating the crevices, etc., several times a year.

This is an excellent service and worth

the expenditure.

There is no end to the details of housekeeping but with a good start one learns as one goes along and this phase of hospital work becomes most fascinating. A nurse superintendent quickly learns that she has to have knowledge of many phases of hospital management but if she is willing to learn and meets all situations with an open mind, there is always help.

Bedside Nursing—An Essential Service

C. E. M. ROWLES

THE FACT that bedside nursing is an essential service should not be questioned by any nurse who is a worthy member of her profession; neither should it be the subject of debate on the part of any who come in contact with nursing in any way. After many years of experience in various fields, I realize as never before that at the core of all our learning is something that has been a part of all nurses since the beginning of time. I refer to that desire to serve humanity in general, and suffering humanity in particular, which should activate all candidates for, and members of the nursing profession, and which should serve as a guide in all branches of work in which nurses are now participating.

It is a far cry from the earlier days when a nurse's knowledge was limited and her initiative cowed, to the



Jensen, Redeliff, Alta.

MARY ROWLES

present with its chances of development. Many factors have been responsible for this, notably, the rapid advance of the sciences, including the discoveries in the field of psychology, the emancipation of women, and the higher level of education among nurses.

The modern nurse should be a creature of many talents and gifts, ready to adapt herself to any circumstances, and able to give comfort and contentment to those around her. We cannot create this individual by pouring certain potentialities into a mould, just as we are unable to classify all our patients under certain headings. In either case, no two individuals will ever be the same. Nurses will venture into new fields, will encounter peculiar problems of their own; and patients, although suffering from identical diseases, will exhibit unusual symptoms and characteristic mental reactions. In every case there is a nurse who is able to cope with the particular patient in question but, unfortunately, these two seldom meet. It is left to us, as individuals, to render what service we can, as intelligently and as competently as possible, to whatever patients may be ours.

This situation brings into being many problems, depending upon the character and disposition of both nurse and patient. That these problems may be solved is the primary concern of the nursing profession, and the solution usually lies in the provision of adequate and skilful bed-

side care for the patient. It sounds like an easy solution, but nurses in the various fields of nursing know that it is not as simple as it sounds. Each case and each field brings its difficulties and, if these are to be surmounted and efficient service rendered, nurses must have an intelligent desire to understand and serve their patients, and must be given the opportunity and time to do so.

In the course of my nursing career I have encountered many of these problems, some of which have been overcome and others which remain unsolved. In the light of my experience, I would like to present some facts for consideration—not endeavoring to prove that bedside nursing is an essential service, but taking that fact for granted, and showing how it may best be provided.

THE STUDENT NURSE

When the young student first enters the school of nursing, her conception of the art she is about to learn is vague. It is a compound of Florence Nightingale, nurses as depicted in the movies, and ministering angels. am afraid that most of us approach our chosen profession knowing far too little of what is ahead. Looking back on my first days in hospital, I recall my disappointment at spending so many hours in the classroom, and my ambition, tinged with fear, to venture into the wards and really to do something for one of the patients. That bedside nursing is an essential service the student learns through a process of trial and error. How many of us can remember the patient's petulant complaint that the pillows were not arranged in the competent manner of Miss Smith—the same Miss Smith being a private duty nurse of many years' experience, to whom pillows were things made to do her bidding, and not shapeless masses of feathers always lumpy in the wrong places.

Unfortunately, in these hectic days of shortage of nurses, both graduate and student, and of an increased curriculum that at times seems to stress certain sciences to the exclusion of the nursing arts—at least to the

mind of the bewildered student-it is small wonder that many of these skills are in danger of being lost. The student still learns how to make a bed, and how to make a patient comfortable, but how often does she find the time to do these things in such a way that she feels satisfied with her work, with the patient comfortable and relaxed? How often must she refuse the request of the patient because she hasn't the time? How often must she leave certain procedures unfinished or imperfectly accomplished, because it is time for lecture?

There are certain aspects of this problem—that of impressing upon the student nurse the necessity of perfect bedside care—that are irremediable at the present time. Until students have more time to learn the art of nursing, and then to put these principles into practice, there is a danger that this side of our professional knowledge will be neglected or imperfectly learned. However, as a final thought in the problem of the student nurse, may I ask you to consider what of the student who has taken her course in the last few years of stress? What of her reaction to nursing in general and bedside nursing in particular? Can she be judged in the light of the experience of those of us who assimilated our art during more leisurely and less complicated days? It will be our duty, more than ever before, to help these young women to a better understanding of the true meaning of our profession.

THE PRIVATE DUTY NURSE

When a patient requests, or a doctor recommends, the services of a private duty nurse, it is usually because something extra in the line of bedside nursing is required. The day of the spoiled, indulged patient, retaining and treating her nurse as something little better than a superior ladies' maid, has gone for the time being, and let us hope it will never return. The private duty nurse should be, and usually is, the bedside nurse "par excellence"; and I think that private duty, properly accom-

plished, must be nearer the ideals of Florence Nightingale than any other

branch of our profession.

During many arduous years, private duty nurses have soothed innumerable patients, relieved countless pains and stresses, been at hand through long and weary nights with the drink of water and the cheering word, and at the same time have kept in touch with what was new in their profession, travelled weary miles to and from work, and been the victims of unpaid services. Now that hours are shorter, these heroines—and only too often they are the unsung heroines of our profession—are able to lead a fuller life, and find time for other activities. which things are needed if their present high standard of work is to be maintained.

As one whose experience in the private duty field was short, I take this opportunity of pointing out the role played in bedside nursing by the private duty nurse. She receives no medals or decorations; she has not a suite of rooms in the nurses' residence. No regular hours are hers. Plans cannot often be made and such as she has are frequently broken. It is not an enviable lot, but I am sure that the private duty nurse, who enjoys her work and makes of it the perfect thing it so often is, must have some satisfaction that the rest of us seldom attain, no matter how publicized our work may be.

THE MATRON OF A SMALL HOSPITAL

I wonder how many nurses have shared the experience of being the matron of a small hospital on the prairie? When one's duties include such varied activities as ordering supplies, keeping accounts, collecting bills, planning menus, and hiring personnel, both professional and substaff, and at the same time taking the responsibility of perhaps fifteen to twenty-five patients, including the supervision of operating-room and case room, ward routine and simple laboratory work, it is small wonder that some phase of the work is neglected.

Only too often it is the patients

who suffer. When the hospital board is asking for ledgers and bills to be up-to-date, the medical staff is requiring help for surgery and obstetrics, the cook is asking for permission to buy fruit for canning, and salesmen are waiting to be interviewed, it is often impossible that patients shall receive more than routine care. This example has not been taken from a "Nurse's Nightmare"—it is an actual example of life in a small hospital of fifteen beds, staffed by two nurses, (one of whom was the matron), one ward aide, and a cook. In addition, life was made more interesting by coal-oil lamps, coal stoves, and water

in a pail.

What of the bedside nursing under these conditions? Is it not as essential there as in the large city hospital? It is often far more important, as in these small places patients are taken to hospital only when acutely ill, after travelling many tiring miles over bad roads in uncomfortable vehicles. To the weary mother from the remote farm, her period of convalescence following confinement represents the only time in her life when she is able to stay in bed and be attended by others; when clean white sheets are put on her bed, without a thought of the countless pails of water that must be carried for the washing at home. which has to be done over a tub and wash-board. Often the hospital diet is the most varied such a patient has had for years, as fresh fruit and meat are luxuries when one lives many miles away on the prairie. Of course, there are cases like these in the larger hospital, but possibly not in as great a proportion to the total number of patients, and I do make the plea that the matron of the small hospital shall have more time to be a nurse, and less obligation to be a Jack-of-alltrades. The prospect of work in a remote place is not attractive to young graduates, but even a short time in a small hospital can provide one with experience that is invaluable. Like many other phases of nursing it is not glamorous, but the feeling of satisfaction given by work well done is very warming, and will make one's

heart glow for years with the memory.

DISTRICT NURSE

district nurse, who travels many miles on horseback, wagon, or sleigh, and arrives far from all sources of supply only to discover a pneumonia case with a temperature of 105°, knows the meaning of bedside care. Not only does she bathe and care for the patient, often preparing meals, but she has to cope with many other problems, which cannot be classified under the heading of nursing. After all, are we not taught that a nurse cares for the patient both physically and mentally? Of what avail is it to provide physical care for the mother of a family, be it done ever so perfectly, if her mind is distressed about who will prepare dinner for the children? Bedside nursing. in the vocabulary of the district nurse. is an elastic term, and some of her activities would probably be looked upon with jaundiced eye by those whose professional life has never gone beyond the boundaries of the larger institutions.

It is essential that the district nurse be a good bedside nurse, but she must also possess many other talents. As in all public health work, she must be able to instruct others in the care of the patient, and that cannot be done unless she herself is perfect in her skills. However, though her skills may be perfect. without that touch of humanity which sets her above the common run of individuals, they will be sterile and comfortless to the patient. Bedside nursing is often carried out with great difficulty under these circumstances, sometimes even with hardship for the nurse; but where is the challenge if the path is always smooth? shall we find an improved means of bedside care if no problems arise? The district nurse, with her difficulties and innovations, can make a lasting contribution to our knowledge of the art of nursing.

INSTRUCTOR AND ADMINISTRATOR

We have seen the importance of bedside care from the viewpoint of

those who give care to the patient, but the picture has another side, and is not complete without a consideration of the problems of those who are called on to provide this service through the medium of others. Above all, it is the duty of the instructor to train nurses. As a former instructor, I know how joyful a thing it is to find a student who always knows the right answers in class, whose examination papers are perfect, and whose records and charts are exemplary. But I also know what a disappointment it is to find that this same student entirely lacks that something which is a part of all true nurses. The responsibility of the instructor in the training of candidates for the nursing profession must not be minimized. Especially in these days of shortage of applicants, it is often a temptation to accept an unsatisfactory student at the end of the preliminary period, and more particularly if that student has shown aptitude in the classroom. Although it is desirable that a student be really a student, in the sense that she is diligent in study and theory, we must not lose sight of the fact that to the patient it matters not how many marks her nurse made in anatomy, so long as she is able to give a soothing backrub, and to straighten the draw-sheet in a satisfactory manner.

Superintendents of nurses, supervisors, and head nurses all carry the responsibility for the service provided in the hospital; and to the person purchasing that service it means only one thing—bedside care. Only too often the supervisor, worried about the mechanics of ward management-arranging hours off duty, holidays, mealtimes, visiting hours, lecture periods, and doctors' rounds is called on to listen to complaints that the flowers have not been arranged today, or that the bell was left where the patient could not reach it. Insignificant things, perhaps, but so important to the patient's mental comfort.

We know it to be an impossibility for the supervisor or head nurse personally to give or oversee each patient's bedside care, but we do know that it is through them that others will be inspired to do their best-or will be doomed to failure. It is sometimes easy to lose sight of this fact when other problems of an executive nature are begging for attention. The Powers-that-Be seem at times to place records and supplies before the comfort of the patient, although on their side of the eternal argument they have the fact that these same records and supplies are ultimately designed to reach the same Bedside nursing should be of primary interest to all who are concerned with the care of the sick. It is our commodity that we have to sell surely we want to have satisfied customers!

THE NURSING SISTER

It would not be complete to close this discussion without a word about bedside nursing from the viewpoint of the Nursing Sister. When casualties were admitted by the hundred, and the census of the ward sprang from 0 to 50 in half an hour, it was very difficult to decide what needed most to be done. When supplies were either short or lacking, certain hospital routines had to be discarded, and bedside care became a thing of imagination rather than of rote. I think many of us will recall the look of satisfaction on a man's face when he was put into a clean bed, dirty as he was, and when he was given a meal not taken from a ration box.

To the wounded soldier, the Nursing Sister was a link with home, and many of us will never forget the pleasure on the face of a casualty when he found that the Sister came from "his" part of Canada. When one is far from home these things hold a magic that is not present under normal conditions. It is perhaps easier to satisfy a man who is worn out with fighting and travelling, and

who wishes only to rest, than the average patient in "Civvy Street," and the gratitude of the patient is magnified accordingly. It was bedside nursing in its primitive sense, and it brought many never-to-beforgotten lessons, chiefly, I think, that successful bedside care takes many forms. It is physical, mental, and sometimes spiritual; it is variable according to conditions: it may be highly skilled, needing intricate equipment, or it may be the most simple thing in the world. It was our job to see what needed to be done, and to do it, irrespective of conditions, equipment, and personal comfort; and it was a job that brought its own reward.

THE PATIENT

After many years of learning, and then teaching others that the patient always comes first, this very important person has been left to the last in this discussion, perhaps because we all know what bedside nursing means to the patient, whether in hospital or at home. Any of us who has been ill can recall the morning after a restless night, when a nurse in snowy apron came in at the door, and with little fuss, and probably fewer thanks, created order out of chaos, and left us sleeping peacefully, reassured, and contented that all was well with the world. Or the night when pain was too close a friend and one wondered whether morning would ever come! That little student nurse, who came in and rubbed the aching back or smoothed the pillow, somehow banished all the bogies that had been there so short a time before.

With memories such as these we cannot doubt that bedside nursing, as such, will always be an integral part of nursing, without which our profession might be built on sand, instead of on that very firm rock of service to humanity.

Correction

The work of the leper hospital at Carville, Louisiana, is supported by the Federal Government of the United States and not by the American Mission to Lepers as inferred in the article on page 1051 of the December, 1946, issue of the *Journal*.

The Late Cancer Case

GEORGE S. YOUNG, M.D.

COMEWHERE between 33 and 38 per cent of all patients with cancer presenting themselves for treatment recover, at least in the sense of being free from symptoms at the end of five years. But these figures must not be confused with the much larger percentage of recoveries in cases where treatment is early and adequate. The first figures quoted include far-advanced cases and also those in which surgery and radiation are still indicated, although not with the same promising outlook for cure as in the early cases.

However, we cannot escape the fact that, under the present management of cancer, approximately twothirds of all cases reach the stage where apparently all that can be done is to relieve the patient's discomforts as far as possible and to hope that the road will not be too rough. Sometimes one is even tempted to hope that the end of the road may not be too far away. Of course, the road could be shortened by giving a lethal dose of some drug like morphine. Euthanasia in such cases has long had its advocates. Theoretically, it sounds all right. Why prolong suffering which can end only in death? does it always end in death?

The fact is that rarely, if ever, can it be said that a patient is absolutely incurable and must inevitably die of cancer. There is the possibility of a wrong diagnosis. Biopsy is considered to be the final court of appeal and yet medical literature contains many instances in which the biopsy diagnosis was found ultimately to be a mistake. X-ray diagnosis has a greater percentage of error than biopsy. diagnosis from clinical observation alone is notoriously uncertain. Then there is the faint chance of spontaneous cure or regression of a malignant growth. Cancer of the colon or rectum may allow the patient a fair measure of health for several years

after intestinal obstruction has been relieved by a simple colostomy and the same may be said of the recent use of stilbestrol in the treatment of

prostatic cancer.

In view of these possibilities the door of hope should seldom, if ever, be closed against the cancer patient. Certainly the situation should be discussed frankly with at least one member of the patient's family. And this brings up an old question: Should a patient be told that he has cancer? Remember that this article deals only with the late cancer case. he has reached the supposedly incurable stage and hasn't learned of the diagnosis at the outset it would seem needless to tell him now, unless he has business affairs to settle or asks a direct question. This applies particularly to old people whose condition puts surgery and radiotherapy out of the question. Frequently patients know the answer themselves and actually avoid asking questions. Whether they know the truth or not it is better for them (and their families) to fight and lose than not to fight at all.

Roughly about one-third of the late cancer cases spend their last days in a hospital. Leaving aside sentiment there would be much to be said for this if there were institutions specially planned for the care and treatment that supposedly incurable patients require. Such institutions could be operated with less expense than general hospitals. At present the great majority of advanced cancer patients are cared for at home and their supervision falls to the lot of the

family doctor.

Now what can be done for these patients? Certainly they will need drugs to relieve discomfort, beginning with simple drugs like aspirin, then passing on to the barbiturates and finally to opium derivatives. There is a wide choice here with room for

careful selections to meet individual needs. Habit-forming drugs will be

avoided as long as possible.

But this is only a part of the treatment. The patient will not be confined to bed unless there are definite reasons for keeping him there. The hours are longer in bed than in a chair. If he must stay in one room it should be chosen with attention to warmth, daylight, sunlight, and ventilation. Mental occupation should be encouraged even if it means working on a cross-word puzzle or playing some simple game. Anything that distracts attention lessens pain. A nurse who can build up a fighting

spirit against heavy odds is doing her patient an invaluable service.

Then there is the question of diet; patients with advanced cancer are likely to develop vitamin deficiencies which can be controlled. Endocrine disturbances like hypothyroidism may occur and be helped by treatment. Severe anemia may be relieved by iron or liver extract.

These few suggestions are offered merely to emphasize the importance of a definite plan in the treatment of late cancer. Much of it must be psychotherapeutic and its success may depend on the nurse more than on any other person.

New Textiles

People who have been accustomed to regard cotton, woollen, and linen fabrics as the most suitable, lasting, and satisfactory materials from which to fashion clothing or household necessities are due for a pleasant surprise when the new synthetic fabrics become available for use.

According to the experts, the new textiles will be easier to look after; laundering will replace dry cleaning in many articles; others will be mothproof, shrinkless, and greaseless.

A wool-like product made from the casein protein of skim milk, known as Aralac, is warm, soft, and lustrous, but not quite as strong as wool, especially when wet. It is, therefore, seldom used alone but is blended with spun rayon, natural wool, or cotton. However, unblended Aralac has been utilized in coat interlinings, batts for filling comforters, and in felts. The versatile soybean has added another child to its already large family. The development of the soybean textile has not gone beyond the fibre stage, but experiments showed that, although it is weaker than wool, it is almost as warm and has good resilience. Another synthetic wool-like fibre is being developed in England from the protein content of the kernel of a peanut. This is made in short staple lengths. While not strong enough to be used alone, it is said to be excellent in combination with wool. It is mothproof and much cheaper than wool.

New developments in rayons are also coming to the fore. Certain dyestuffs on acetate rayon, notably shades of blue, are now being treated with "Chromostatic" finishes to combat gas fading. Methods have been found to stabilize rayon fabrics to overcome shrinkage and stretching. While in the past the tensile strength of ordinary rayon yarns was comparatively low, high tenacity rayons are now being distributed by Canadian textile companies.

Nylon foundation garments and lingerie are on the books for the near future. An early appearance of "bareleg" hosiery is predicted—nylon stockings circularly knit and steam-set to give them permanent shape. The permanent setting feature of nylon will be an advantage in neckwear and other garments which can be trimmed with pleated ruffles. If set properly by steam the pleats will not budge when laundered and will be as crisp and sharp after washing as before.

Considerable research is being conducted in the production of synthetic fibre from seaweed. Chemically, this fibre will be one of the metallic salts of alginic acid, a seaweed product, and will probably be known as alginate rayon. Its importance in textiles will lie chiefly in the fact that it will be missing in the finished product. Alginate fibre will be twisted in with other untwisted staple fibres like cotton and wool. After it is woven, the material will be immersed in a dilute alkali solution which dissolves the alginate, leaving a soft untwisted yarn fabric. Delicate embroidery, crepe and lace effects may thus be obtained.

-Canadian Home Economics Newsletter

A Rare Opportunity

The congress of the International Council of Nurses, which is to be held in Atlantic City early in May, provides the first opportunity since 1929 the great majority of the nurses in Canada have had to attend this gathering. Few of us will be able to afford either the time or the money to travel half-way around the world to be present at future congresses to join with our colleagues from many lands in thinking and planning for the future.

In the months that have elapsed since the formation of the United Nations Organization, we have all seen how important yet how difficult this world-wide co-operation is to achieve. It is natural that this should be so since the ideologies, customs, habits, and the thinking, planning, and practice of each country present so many varied patterns. Today we are being forced to think internationally. If our civilization is to go forward, nay, even to survive, there must be recognition of the points of difference and conscious efforts must be made to find the means to weave these differences in thinking, in the way of doing things, into a fabric that is a blending of all the elements. The risks attendant on going forward together are much less than the risks if each tries to stand still alone.

The Notes from National Office in the February issue of the *Journal* contained the twenty-two points on which the United Nation Health Organization is founded. Read them again and visualize into how many of these the structure of nursing the world over penetrates. Such functions as: "providing . . . health services," "eradicate epidemic, endemic and other diseases," "prevention of accidental injuries," "promote maternal and child health and welfare," "foster activities in the field of mental health," "developing an informed public opinion . . . on matters relating to health"—these functions are all as familiar to Canadian nurses as the routine duties on our wards or in the office of the school nurse. Yet they are all part of the pattern of international thinking.

The direction in which nursing education will develop in the years to come is a problem common to all countries. The recruitment of suitable candidates to enter schools of nursing, the curricula of these schools, the opportunities for affiliated experience in psychiatry, tuberculosis, public health nursing, the shortage of well-qualified instructors and supervisors—none of these is peculiar to Canada. Discussion of all of these points internationally is valuable and should have far-reaching effects.

Though the convention hall in Atlantic City is large, it does not have elastic walls. Hotel accommodation will be at a premium. If you want to be there, to participate in the sessions of the Congress, your reservations should be made at once. It is a golden opportunity for nurses of Canada to mingle with their international colleagues, but you will have to act promptly.

—M.E.K.

Accommodation in Atlantic City

Nurses who are planning to attend the Congress and who have not yet made reservations for accommodation are requested to do so immediately. Single rooms are very limited in number so please arrange to share twinbedded rooms. Application forms may be obtained from your provincial executive secretary. Send them to the

chairmen of the following committees at 16 Central Pier, Atlantic City, New Jersey:

Catholic Sisters and Deaconesses: Wilkie Hughes, R.N:

Student Nurses: Mrs. Gordon Salmon, R.N.

All others to: Housing Bureau.

Plans for Visitors from I. C. N. Congress

National Office, C.N.A.

During the past year it has been the privilege of National Office staff to welcome, on behalf of the Canadian Nurses' Association, visitors from many lands and places. Such visits are extremely interesting and valuable in so far as National Office is concerned, and from reports received from former international visitors it is believed that such contacts are mutually beneficial.

From enquiries being received, it is anticipated that many nurses who are planning to attend the International Council of Nurses meetings in May will also include in their itinerary a visit to Canada. Executive Committee of the Canadian Nurses' Association has arranged for the general secretary to be relieved from other duties following the International Council of Nurses Congress so that she may devote her entire time to international visitors. desired. National Office staff will interpret the activities of the Canadian Nurses' Association and will also give an overview of the Canadian nursing scene.

Information and assistance in program planning will be given as well to those who wish to visit other parts of

Canada.

School for Graduate Nurses, McGill University

The School extends a welcome to nurses who are planning to visit Montreal following the International Council of Nurses meetings in May. While the School will not be in session then, its staff will be prepared to interpret its program and to arrange for conferences which might seem desirable. It would be appreciated if nurses

wishing to visit the School would indicate in advance what type of program they would like, the dates of arrival, and how long they might wish to stay.

School of Nursing, University of Toronto

In view of the number of nurses who may be considering a visit to the School, special plans have been made to provide, during the coming months, a limited program for the particular purpose of meeting requests from nurses who plan to attend the I.C.N.

meetings in May.

This School is willing to receive visitors at both of the following periods: May 19 to May 30, inclusive; June 9 to June 20, inclusive. A general program will be offered but this will allow for some particular adaptations to meet special requests. The School cannot receive any visitors at all between April 15 and May 19, or during the first week of June; nor can it receive visitors at any time during the coming summer except in the two periods stated above.

Visitors are requested not to plan to remain less than the proposed twoweek period, as shorter visits yield little profit. However, everything possible will be done for anyone who might wish to come for a shorter period, providing that the beginning of the visit coincides with one of the dates given above, namely, May 19 or June 9, and providing the visit is not less than three full days in length, and that it is made only for the purpose of conference, not for study of the work of this School. The School regrets that it will be impossible to receive visitors on any other dates, but there are not enough staff members here to make anything more possible.

He who fears criticism is hopeless. Only those who do things are criticized. The idler is lost sight of in the march of events, but the doer is watched and criticized.—THOMAS JEFFERSON

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Use of Volunteers

HELEN McARTHUR and SHEILA MACKAY

MISS Ruth B. Freeman, in her book "Techniques of Supervision in Public Health Nursing,' stated that "Thoughtful use of every available facility will release time for many real nursing tasks and promote better total service to the family. Voluntary workers and nurses' aides are often utilized at tasks which are far too limited in scope for the general and specific training they have had." And therein lies the gist of a problem which has been attracting the general attention of Canadian public health nurses for some time. In December, 1943, something of an attack was made upon it when the Public Health Nursing Section of the Canadian Public Health Association published a study on the "Use of Volunteers in Public Health Nursing" in the Canadian Journal of Public Health. And in 1945 the matter was broached again, this time by the Public Health Nursing Section of the Canadian Nurses' Association, when it was decided that, in view of the fact that the valuable service rendered by volunteer organizations during the war might be lost to peace-time programs if steps were not taken to organize the service, a follow-up of the first study would be extremely timely. Accordingly, this was undertaken by the Education Committee under the chairmanship of Miss Madeline McCulla.

Questionnaires were sent to the Public Health Sections of the nine provincial associations for distribution to all voluntary and official agencies in each province. Their purpose was to ascertain whether or not the use of volunteers is on the increase in the public health field and, simultaneously, whether or not there are techniques being developed to increase the effectiveness of their service.

The results were as follows: Replies were received from fifteen voluntary and twenty-one official nursing organizations. Of these, six official agencies stated that a volunteer program had been initiated in their organizations since 1942. Eight official agencies reported that they were recruiting volunteers from non-health agencies such as the Central Volunteer Bureaus, Red Cross Corps, and lay committees. Findings seemed to indicate, however. that volunteers were usually recruited through personal contact by the nurses—often through their participation in community welfare councils of various types, although it was reported by one branch of the Victorian Order of Nurses that its local committee had made itself responsible for the provision of volunteer assis-

As it is an accepted fact that, in order for volunteer service to be effective, a careful plan must govern its development, questions on training and supervision were included, and replies to these indicated that in eight of the agencies reporting, such a

plan was in effect. For example, in one official agency an orientation program, including an outline of the agency's services and the explanation and demonstration of duties to be undertaken by volunteers, had been developed. A monthly report on each volunteer, emphasizing such points as regular attendance, general ability, reliability, and interest was also forwarded to the volunteer agency providing workers. Another organization has formed its volunteer workers into committees and gives careful training to each committee in one specific line of duty. In still another instance, the training and supervision is done under the Red Cross Corps which gives courses in home nursing and first aid.

Three agencies reported postwar plans for the use of volunteers. Of these, an official agency plans to continue their use in child health centres and tuberculosis surveys, while another official agency is having the Red Cross make a survey of the crippled children throughout its home province. The third, a voluntary agency, plans to continue with volunteers in baby clinics and possibly in the bedside care of chronic patients.

In reply to the question, "Is a plan being considered to utilize volunteer workers, who have been organized for war services, in your postwar program?", many admitted that, though the idea undoubtedly had merit, very little planning towards this end had been done. A few replies gave the opinion that the use of volunteers is limited and that "if public health service is worth having it's worth paying for." However, "We could use volunteer the reply, workers more than we do," seemed to sum up the general concensus regarding the position of the volunteer in public health nursing practice in Canada at the present time.

To summarize then, it would seem that personnel shortage is undoubt-

edly the headline problem of health agencies at the moment, and that volunteers could do much to alleviate it. As previously emphasized, however, they not only need to be trained and supervised but, to maintain their interest and enthusiasm, they must be given encouragement. It is believed, too, that even when staff shortages are relieved by trained personnel, the volunteer worker will be able to render many services. which will allow the public health nurse to devote more time to phases of her program which she had not previously been able to develop. In support of this view, the manual published by the National Organization for Public Health Nursing has made the following statement: "It has been found that in agencies where time has been taken to recruit volunteers, teach them, and develop their capacities, the work of the agency has flourished through wider community undertaking, and time and money have been saved for the expansion of the strictly professional phases of the program."

The study upon its completion was presented at the meeting of the Public Health Nursing Section of the Canadian Nurses' Association on July 3, 1946. At that time, it was suggested that study of the problem be continued by the Education Committee in the coming biennium, and that definite recommendations regarding the qualifications, training, and supervision of volunteer workers be drawn up, as well as suggestions for methods of co-operation with women's groups who are ready to provide such workers. The hope was also expressed that publication of the foregoing summary of the study would be an incentive for further expressions of opinion, in the form of articles in The Canadian Nurse, by public health nurses who are acquainted with the use of volun-

teer workers.

An Addition

Public health nurses are asked to add the Health League of Canada, 111 Avenue Road, Toronto 5, Ontario, to the list of sources of health education material found on page 1031, December, 1946, issue of *The Canadian Nurse*.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Our Own Page

CANADA'S BORDERS stretch far and wide—to the east and the west, to the north and to the south. How difficult it is for us to keep in touch with one another in our vast Dominion! Many of you already know that through the pages of The Canadian Nurse you are able to be a link in a strong chain which does bind us together. It has been found in the past, however, that more active participation is taken by some than by others. This is rather unfortunate. as in this way it is difficult to find hidden talent. Then, too, it is hard to appreciate the other fellow's undertakings and understand his viewpoint if it is not made known to all. It was this need of unity and understanding between ourselves that gave birth to the program which we are about to outline.

At an executive meeting of the Institutional Nursing Committee of the Canadian Nurses' Association, a convener for Publications was appointed. At this meeting it was felt that a subject of keen interest to all was that of personnel policies and procedures. Here was something where everyone could actively participate! The first step taken by the convener was to write to each province to explain the plan, ask for approval and the privilege to set up a small committee who could draw up the subject in detail and then allocate a topic for each province. The replies were most gratifying, all showing enthusiasm and the need for such an undertaking. We were on our way!

In drawing the plans the committee felt that it would be necessary to develop the articles in a fairly uniform pattern, particularly when the articles were to be in sequence. Nine headings were developed and each was divided into five parts. The following are the various headings and each will be discussed under the parts of: A. general floor duty; B. private duty nurse; C. head nurse; D. supervisor; E. teaching staff.

1. Personal interview: (a) application; (b) use of the placement bureau; (c) references; (d) interview.

2. Job analysis and orientation.

3. Salary schedules and promotion.4. Annuities and pension plans.

5. Living and working conditions, including health program, sickness, vacation.

6. Transfers, discharges, and methods of resigning; the responsibilities of a position.

7. Personnel guidance.

8. Value of adequate supervision.

9. In-service education; survey—what can be done—what is being done.

The first article is to come from Prince Edward Island. From there we shall hear from the prairie province of Saskatchewan. Then—watch your Canadian Nurse!

Of course, a program like this could not be carried out if it were not for the co-operation being given and which we are confident will continue

to be given. No one person—no one committee—no one province—can do it alone! With enthusiasm, co-operation and active participation from all; we can keep the articles flowing for *The Canadian Nurse* and in this way appreciate the other person's achievements, her problems, and her work. All this will show that no matter where we are, whether it is in the north or south, in the east or the west, our

problems are still somewhat similar. We will find that in sharing our achievements and our problems, we can prevent as well as solve some of our difficulties. What better way to link ourselves together than this!

MARGUERITE E. SCHUMACHER Chairman, Sub-Committee on Publicity of the Committee on Institutional Nursing

A Short Work Week

A Tennessee hospital has set a precedent for the nation's seven thousand voluntary hospitals by proving the 40-hour week for all hospital personnel is possible as well as profitable, according to a report published in the January, 1947, American Journal of Nursing. The 40-hour schedule has been operating successfully since October, 1945, at the Holston Valley Community Hospital, Kingsport, The superintendent's report states there is "no comparison between the hospital today and the hospital a year ago. There is more efficiency all along the line; more work is being accomplished in a given time and the quality of the work has greatly improved. In addition, the illness rate among nurses in particular has dropped noticeably."

That working hours rather than salaries were a basic cause of the shortage was evident from an informal survey made among former nurses who served in the Army and Navy or who had left hospital nursing for similar positions in industry, doctors' offices, schools, and other non-institutional fields. Many stated they "wouldn't work in a hospital again no matter how much they were offered," but all agreed they "missed hospital work and found it more interesting than other nursing positions."

It was this opinion that convinced Miss B. W. Mears, the superintendent, that the hospital must find a way to shorten hours. With salaries remaining the same, work schedules were made out on the basis of a straight 8-hour day and 5-day week. The medical staff co-operated by agreeing that no elective work should be done in the operating-room, x-ray, or laboratory on Saturdays or Sundays. Moreover, schedules were arranged so that each nurse had off one long week-end a month—Saturday and Sunday of

one week and Monday and Tuesday of the next—thus having the four days of the two weeks run consecutively. It was unnecessary to add extra personnel except in certain departments that operated regularly on a 24-hour schedule, such as the emergency room.

To the surprise of everyone, as much if not more work was accomplished in five days than had been accomplished previously in five and one-half and six days. This was in spite of the fact that when the 40-hour plan was being considered, "we did not have enough nurses to cover the hospital even if they worked 72 or 84 hours a week, for the hospital was at least 50 per cent understaffed."

Miss Mears admits "it would be foolhardy to say we have all the nurses we need, but we do have the number set as our quota when the 40-hour week was adopted." Nor does the hospital have as high a ratio of graduate nurses to patients now as before the war because it has been found that "many duties formerly performed by graduate nurses can safely be assigned to nurses' aides or attendants, thereby conserving the time of the graduate nurse for professional duties."

Miss Mears concludes her report by stating that while the 40-hour week is not the whole answer to the personnel dilemma most hospitals are experiencing, it is "a big step in the right direction."

Holston Valley Community Hospital is a typical general hospital of average size, having about 150 beds. It has the distinction of having pioneered the 40-hour week among voluntary hospitals. Another policy inaugurated by the Kingsport institution, which has long been urged by nurses' associations, is the payment of higher salaries for the less desirable night and evening hours.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Le Registre Ville-Marie

ANNE-MARIE ROBERT

Afin que toutes les infirmières soient renseignées sur cette question des aides, actuellement à l'étude, nous publierons trois articles dans cette Page. Le premier, un article de Mlle Anne-Marie Robert, directrice du Registre Ville-Marie, nous fera voir la situation à Montréal.

Dans un prochain numéro, Mlle G. Hall vous donnera le point de vue de l'Association des Infirmières du Canada.

Dans le dernier article de la série, Mlle

F. Waugh vous parlera de la législation du Manitoba concernant les aides, et de son expérience comme régistraire.

Il est à souhaiter que les présidentes des amicales de nos hôpitaux éclairent leurs membres sur cette question.

Toutes les suggestions que l'on voudra faire à ce sujet seront reçues avec reconnaissance. Veuillez adresser vos lettres à l'Association des Infirmières de la Province de Québec, 1538 ouest rue Sherbrooke, chambre 506, Montréal.

Le Bureau des Infirmières du Registre Ville-Marie de l'Association Catholique des Infirmières de Montréal a été fondé par un groupe d'infirmières distinguées. C'est grâce à leur dévouement que l'organisation difficile du début a pu être maintenu. Je tiens à leur rendre mon plus respectueux hommage.

Ce bureau a été ouvert au public en mai 1936, et depuis le public a bénéficié d'un service continu de 24 heures. A sa fondation le registre comptait 104 membres. Ce service a été organisé pour les infirmières professionnelles, dans le but d'assurer au public les services de gardes-malades compétentes et qualifiées, car la profession d'infirmière est essentiellement une profession de service à l'humanité.

Depuis dix ans qu'existe ce registre, les demandes n'ont cessé d'augmenter. La preuve est, qu'il y a cinq ans, soit en 1941, nous avons répondu à 2,674 appels qui ont donnés 11,987 jours de travail et 1,127 visites et traitements

à domicile. Nous comptions 255 membres. L'an dernier, en 1946, nous avons répondu à 9,646 appels qui ont donnés 83,051 jours de travail, et avons fait plus de 980 visites et traitements à domicile. Nous pouvons constater qu'en cinq ans nous avons eu huit fois plus de travail et cependant beaucoup d'appels n'ont pu être remplis. Nous avons à date 430 gardes-malades professionnelles membres de notre registre.

Permettez-moi d'ajouter qu'à notre bureau en plus des demandes de service et des placements, nous nous faisons toujours un plaisir de donner les informations qu'on nous demande afin d'intéresser le public et les gardes-malades à notre profession. N'ayant pu répondre à toutes les demandes du public et dans le but de rendre un plus grand service et aussi à titre d'expérience nous avons enregistré gratuitement 24 aides au Bureau des Infirmières du Registre de l'A.C.I.C. dont une aide-malade de Buckingham, 8 aides-bébés possédant un certificat

de la clinique B.C.G. ou de l'Hôpital Général de la Miséricorde, 15 autres aides avant fait des stages comme étudiantes gardes-malades dans différentes écoles. Le nombre est restreint à cause des qualifications requises pour l'enregistrement à notre bureau. Des références contrôlées par nous sont exigées pour ces personnes. En plus, nous demandons à l'employeur l'appréciation de leur travail, ce qui veut dire qu'il y a surveillance, touiours dans le but d'assurer un service plus parfait. Ces jeunes filles bénéficient de notre expérience et de nos conseils.

En 1946, nous avons reçu 956 demandes pour tous genres de services, autre que ceux donnés par une infirmière professionnelle, soit comme aide-bébé, soins généraux aux invalides, surveillance des malades chroniques, etc. Pour chaque appel une enquête est faite afin de s'assurer que le cas ne requiert pas les soins professionnels d'une infirmière.

Nous avons remplies 51 de ces demandes et n'ayant pu répondre aux autres nous avons prié les gens de s'adresser à la Fédération St-Jean-

Baptiste.

De tout ce que je viens de dire, le problème le plus difficile à résoudre est celui des personnes ayant fait des stages dans les hôpitaux comme étudiantes gardes-malades et par conséquent ayant acquis des connaissances dans le nursing, sans avoir obtenu de certificat et faisant du service auprès des malades. Quelle doit être notre attitude à leur égard? Je puis vous répondre en toute franchise que le public les emploie sans connaître leur compétence, leur degré d'expérience, et les raisons qui ont motivé leur départ d'une école du nursing. Le public est-il protégé? Cette jeune fille est-elle protégée?

Personnellement, d'après mes six années d'expérience comme directrice des Infirmières du Registre Ville-Marie, des études que j'ai faites sur les bureaux de placements, j'apprécierais fortement une législation exigeant de toute personne donnant des soins aux malades et recevant pour ses services une rémunération, une licence.

En plus, il me semble que dans une ville comme Montréal un bureau de placement pour infirmières professionnelles, aides, auxiliaires, et infirmiers est indispensable pour assurer au public le maintien et le rétablissement de la santé.

En un mot je crois qu'un bureau de placement est nécessaire pour que chaque cas ou position soient donnés à la personne capable de remplir la tâche exigée.

Cooking with Radar

One of the postwar developments which promises to revolutionize cooking methods is the use of electronic heating, much like the diathermy apparatus, in the form of a "radarange." The Raytheon Manufacturing Company, of New York, has testified that by using the magnetron tube developed in connection with radar for war purposes, food can be pre-cooked in seconds, as compared with minutes by older methods. They demonstrated that, by such means, frankfurters can be grilled in 8 to 10 seconds, gingerbread and biscuits baked in 29 seconds, and hamburgers with onions made ready in 35 seconds.

Electronic devices heat uniformly from the inside to the outside, which is just the reverse of ordinary heating apparatus. The former does not draw heat from the electromagnetic

spectrum itself. Instead, it plugs into the regular power supply line. Its secret is in stimulating electromagnetic impulses which are beamed upon the food or other object.

Preview

In the afternoons and evenings in the vicinity of any of our hospitals, we may see long lines of people bustling along to visit their friends and loved ones who are patients. What about the sick persons whom they are planning to visit? How do they feel about their visitors? How do the nurses feel about them? You will be entertained and, we hope, instructed by the account, "It's Not the Patient . . . It's the Visitors!" by Nona Blake as told to Louise Price Bell.

Notes from National Office

Executive Decisions

THESE summaries have been prepared from reports of various committees and from the general secretary's report presented to the Executive Committee, Canadian Nurses' Association, December 5-7, 1946:

(a) Discrimination in the employment of married nurses: The following motion was conveyed by letter to the National Advisory Council of Service Clubs of Canada and to the Canadian Civil Service Association and other appropriate groups, e.g., provincial and civic departments of health; V.O.N.; Federation of Business and Professional Women's Clubs and the National Council of Women:

That the Canadian Nurses' Association endorse the resolution from the Registered Nurses Association of Ontario regarding the discrimination against specially prepared women on the basis of marriage; and, further, that not only should the matter be brought to the attention of the National Advisory Council of Service Clubs of Canada but also to the attention of the Canadian Civil Service Association and other appropriate groups.

(b) The resolution, proposing a Division of Nursing (see The Canadian Nurse, Sept. 1946, page 799), was conveyed to the Minister of Health and Welfare with copies to other governmental departments concerned.

(c) The resolution regarding Pasteurization of Milk (see The Canadian Nurse, Sept. 1946, page 799) was submitted to the nine provincial Ministers of Health. Replies were received from six provinces—four approved the resolution and one stated that compulsory pasteurization was already in effect. One province did not favor the section of the resolu-

tion which urged that a provincial law be passed requiring compulsory pasteurization because they realized that the passing of such a law would lead to innumerable breaches in many cases, and they did not favor the passing of laws that could not be enforced.

(d) A request was made by the Research Division, Department of National Health and Welfare, Ottawa, for a report from the Canadian Nurses' Association for a study being made by the Interdepartmental Advisory Committee on professionally trained persons. On July 24, 1946, Mr. J. W. Willard, Research Division, interviewed the general secretary. Mr. Willard outlined the purpose of the committee, and explained the method of securing the information required and the possible sources of such information. He explained the necessity of having this report completed by September 15.

Much material was assembled by the general secretary before she left for Great Britain. Miss Ethel Johns undertook the work of preparing the written report. In the absence of the president, Miss E. Cryderman, first vice-president, gave Miss Johns the necessary support and help.

It is understood that the report is being printed by the Federal Government and copies will be available soon for distribution to members of the Canadian Nurses' Association. We now have a report which will be of inestimable value in answering the innumerable requests for statistical data.

(e) International visitors: At the request of Miss M. E. Tennant, director of nursing, Rockefeller Foundation, arrangements were made for conferences between directors of health and nursing services in Mont-

real and Miss Eli Magnussen, director of nursing in the Danish National We endeavored to Health Service. give Miss Magnussen information on the general nursing situation in Canada. During the war she had been a prisoner for seven months (for which she accepts no sympathy) and says it was an interesting experience. She impressed us as being a woman of great courage and high character.

Section Reports

General Nursing Section: Reports show a general shortage of private duty and general staff nurses, with an increase in requests for private duty nurses and a decrease in enrolments with the majority of placement ser-Fewer nurses are accepting positions in doctors' offices. Several provinces reported a study of fees and hours of duty underway, with a view to securing more uniform fees and hours throughout the provinces.

Educational programs are being carried out in all provinces. Reference libraries are being set up with books on counselling, etc., made available for registrars as well as nursing magazines and reference books for members.

Hospital and School of Nursing Section: The following projects are

proposed for this biennium:

1. The establishment of an acceptable nomenclature, with definitions, for the various positions of the professional nurse and her assistants in the hospital field.

2. Job analysis, job description, and job specification as applied to hospital nursing service, the purpose of this

being:

(a) To gather information which will be useful to hospital administrators and placement directors in the selection and placement of personnel. The study should form a basis for improved organization of personnel and division of authority and responsibility. (b) To promote the development of standard practice instruction and work manuals. (c) To clarify our thinking regarding the duties of the professional nurse and the subsidiary worker in hospital nursing service. (d) To gather information which may be used to determine qualifications and preparation

required of workers in the various categories of hospital nursing service. In turn this can be used to determine fair and equitable rates

of pay for each.

3. A series of articles on personnel policies and practices for the hospital nursing staff will be prepared for publication on the Institutional Nursing Page in The Canadian Nurse. over-all plan will be the responsibility of the executive of the Committee on Institutional Nursing; the articles themselves will be the result of the activities of the provincial sections under the leadership of the convener of the Publications Committee.

Committee Reports

British Nurses Relief Fund: The report contained the following recommendations which grew out of the direct observations and conferences in Britain by the convener, British Nurses Relief Fund, and the general secretary:

1. That this fund be continued for the present and that the provincial associations

be notified of existing needs.

- 2. That, as the food situation in Holland has improved considerably in recent months, and as the situation in Britain has not improved and, in point of fact, shows definite food deficiencies, it is suggested that food parcels to Holland be reduced or completely stopped after Christmas, 1946, and that food parcels be re-channeled to British nurses, lists of names to be obtained from the Royal College, keeping in mind that they should be sent to those centres where the necessity is greatest.
- 3. That financial assistance be continued to Britain for at least another year, and possibly longer, for Rest-Breaks Homes, i.e., homes that are being established for permanently injured civilian nurses or those whose hearth has been permanently affected by war. It is suggested that, in sending such assistance, emphasis be placed on using the money for financing the stay of individual members of the profession rather than for overhead expenses or equipment, but that a gift might be made to each one in the nature of some decorative article as a remembrance of the interest that Canadian nurses have demonstrated for their British sisters who suffered so greatly during the past years. Also, that

money be ear-marked for nurses who have suffered as the result of the war but who are capable of receiving vocational training so that they may become independent financially again.

4. The greatest need now in Holland seems to be for certain educational equipment for schools of nursing because of the inability to send money out of the country to purchase it. One hospital with a very large student group was definitely handicapped because of the lack of a Chase doll and yet the teaching program was excellent. A further suggestion worthy of consideration is that, if financial restrictions continue to the point that delegates to the International Council of Nurses Congress are not possible. Canadian nurses assist at least one or, possibly, two Dutch nurses to attend the 1947 Congress by paying for their hospitality during the weeks of the Grand Council and Congress.

At the executive meeting it was suggested that provincial associations be informed of the following needs:

1. Contributions of handicrafts, such as hooked rugs, quilts, and homespun bedspreads, to be sent to the Rest-Breaks Homes for nurses, or donations toward the purchase of cretonnes or chintz for drapes for the living-room or dining-room of these homes could be made. (Such materials are difficult to obtain in Britain and require coupons.) The general secretary is procuring the measurements of the windows so that materials may be purchased in quantity sufficient for this purpose.

2. That food parcels be sent to the nursing staffs in hospitals in Britain, the names of hospitals to be obtained by the Canadian Nurses' Association from the Royal College of Nursing,

London.

3. That we consider purchasing some much needed teaching equipment for schools of nursing in Holland.

The following resolution was unanimously adopted by the executive:

That the provincial associations and any other interested groups be notified of the existing needs; also that the provincial associations notify National Office if they can make a contribution toward bringing a European nurse to the International Council of Nurses Congress in Atlantic City.

It is very much hoped that each provincial association will continue to support this worthy cause for another year. When the districts or chapters have decided upon the project which they will support, will they kindly advise National Office.

Labor Relations Committee: The convener reported on regulations, covering student nurses in Saskatchewan, which were agreed upon by the authorities in the hospital schools of nursing and the Saskatchewan Registered Nurses' Association, and the Registered Nurses' Association and the Minimum Wage Board of Saskatchewan.

In British Columbia a Select Committee on Labor Relations has been appointed to help nurses solve their problems, to participate in conferences with nurses and their employers and to act, if necessary, as a certified bargaining group. Certification has been granted by the B.C. Department of Labor for a collective bargaining unit for the nurses employed by one hospital. The unit is composed of three representatives from the nursing staff of the hospital and the Select Committee on Labor Relations.

The Registered Nurses Association of Ontario has decided to employ a Relationship Adviser to act as a consultant to local nursing groups in the event of any difficulty arising between such groups and their employers.

Legislation Committee: The Constitution and By-laws, together with the proposed amendments resulting from the general meeting, July 4, 1946, were submitted to provincial associations with a letter containing the resolutions which appeared in *The Canadian Nurse*, Sept. 1946, page 798.

The convener reported that she had consulted with the legal adviser regarding the manner in which the C.N.A. should function constitutionally during the transition period from November 15, 1946, until the next general meeting of the association in 1948.

The legal adviser recommended the following procedures:

1. That a third vice-president be appointed to the association. Miss Marion Myers, Saint John, N.B., was accordingly appointed at the Decem-

ber executive meeting.

2. That for the remainder of the present biennium, five representatives from the nursing sisterhoods (to be chosen on a regional basis) be appointed by the Executive Committee. The appointments were as follows: Rev. Sr. M. Beatrice, N.S.; Rev. Sr. Columkille, B.C.; Rev. Sr. St. Gertrude, Que.; Rev. Sr. M. Kathleen, Ont.; Rev. Sr. M. Irene, Sask.

3. The member appointed to be chairman of the Committee on Constitution, By-laws and Legislation, and chairman of the Committee on Labor Relations, Miss E. Flanagan and Miss K. Connor, now become members of the Executive Committee.

4. That two other members be appointed to the Sub-committee of the Executive Committee. Mrs. D. Harrison, Sask., and Rev. Sr. D. Clermont, Man., were appointed.

- 5. That the following chairmen be appointed by the executive: Program Committee, Miss R. Chittick; Committee on Arrangements, Mrs. R. A. McNaughton; Student Nurses' Activities, Miss Frances Waugh; Nominating Committee, Miss Mary Mathewson.
- 6. Dues: That an annual membership fee of One Dollar be collected by the provincial association to which each nurse belongs, to be remitted to the Canadian Nurses' Association by the said provincial association on March 31, June 30, April 30, and December 31, following the date of collection as the case may be. Adjustment of fees for the year 1946 shall be made in January, 1947, to bring the affiliation fees for the year 1946 up-to-date for any increase in membership compared with the previous year. Any decrease in fees resulting from a reduction in membership will be required to be refunded. For 1947, the fees shall not be payable until April 1 based on the membership to March 31, 1947. Quarterly payments will be made on the same basis thereafter.

7. That in order to comply with the resolution regarding incorporation passed at the general meeting, the Executive Committee recommended that the legal adviser be requested to proceed with incorporation.

8. That the final clause in By-law VII, Section 7, be combined with By-law VI, Section 1, to read: "On all questions which have previously been submitted to the Association, members of the voting body at each General or Special meeting of the Association shall consist of the Voting Delegates from the provincial Associations. On all other questions, where the policy of the Association is not involved, any ordinary member may move, second and vote in such manner as the chair may decide."

9. That the titles of the conveners of the three national sections be changed to chairmen of the three

national committees.

National Publicity Committee: It was agreed that there is need for additional pamphlets in various fields of nursing and it is, therefore, recommended:

- 1. (a) That immediate steps be taken to prepare pamphlets dealing with various aspects of public health nursing with the object of clarifying the thinking of nurses who are contemplating this field of nursing regarding the extent, values, and opportunities of this branch, stressing functions and qualifications necessary rather than working hours, salaries, etc. (b) That the preparation of special pamphlets dealing with industrial, orthopedic, and pediatric nursing be the next objective of this publicity program.
- 2. The question arose as to the resources that could be explored to cover the cost of the new pamphlets or publications. It was recommended that every possible avenue of securing financial assistance for additional publicity work be explored, e.g., insurance companies, industrial fields, manufacturers, drug companies, etc., and that the Canadian Nurses' Association endorse the committee's stand that restricted advertising by the sponsor be permitted.

The members of the Executive Committee approved these recommendations and requested that material for the new pamphlets be submitted to the provincial secretaries for approval before being printed.

Royal College of Nursing

The following is a quotation from a letter received at National Office from Miss F. Goodall, Secretary:

Will you please be good enough to broadcast our united thanks for all the beautiful parcels which have been arriving at the College in a stream both before and after Christmas. We are doing our best to distribute them suitably and I know the recipients will be tremendously grateful.

Shoes and Stockings for Greece

National Office wishes to acknowledge and to thank the nurses of Canada for donations of shoes and stockings for the nurses of Greece. Two parcels are on their way to Greece.

Notes du Secrétariat de l'A.I.C.

Ces Notes ont été préparées d'après les rapports présentés par les différents comités et par la secrétaire lors de l'assemblée du Conseil de l'Association des Infirmières du Canada du 5 au 7 décembre 1946:

- (a) Différence établie dans l'emploi des infirmières mariées: La motion suivante fut envoyée sous forme de lettre circulaire à tous les clubs, sociétés, associations de membres du service civil, fédérales et provinciales, services de santé, etc.: "L'Association des Infirmières du Canada approuve la résolution, présentée par l'Association des Infirmières Enregistrées de l'Ontario, concernant des distinctions faites contre des femmes très compétentes, parce qu'elles sont mariées, et en plus demande que cette question soit portée à l'attention de l'Association Canadienne des Employés du Service Civil et autres groupes intéressés."
- (b) La résolution préposant un Département du Nursing (Voir Canadian Nurse, sept. 1946, page 799) fut envoyée au Ministre de la Santé et du Bien-Etre, et des copies furent aussi adressées aux autres départements intéressés.
- (c) La résolution demandant une législation concernant la Pasteurisation du Lait (voir Canadian Nurse, sept. 1946, page 799) fut envoyée aux neuf Ministres Provinciaux de la Santé. Six provinces répondirent quatre approuvent la résolution, l'une d'elles a déjà la pasteurisation obligatoire. Une province n'est pas en faveur d'une loi rendant la pasteurisation obligatoire; il y aurait de trop nombreuses offenses et l'on considère qu'il n'est pas bien de passer une loi qui ne sera pas observée.

(d) La division du Service des Recherches du Ministère National de la Santé et du Bien-Etre, Ottawa, demanda à l'Association des Infirmières du Canada un rapport sur les personnes ayant reçu une formation professionnelle comme infirmière, une étude à ce sujet étant faite par un comité de son département.

Le 24 juillet 1946, M. J. W. Willard, du Service des Recherches, eut une entrevue avec la secrétaire de l'A.I.C. La plus grande partie des renseignements furent préparés par la secrétaire avant son départ pour l'Angleterre. Mlle Ethel Johns prépara un rapport écrit et fut aidée par la première vice-présidente, Mlle E. Cryderman, en l'absence de la présidente. Il est entendu que ce rapport sera publié par le Gouvernement Fédéral et que des copies seront distribuées aux membres de l'A.I.C. Nous avons en mains un rapport d'une grande valeur qui nous permettra de donner une foule de renseignements.

(e) Visiteuses internationales: A la demande de Mlle M. E. Tennant, directrice des Infirmières de la "Rockefeller Foundation," des dispositions furent prises pour que Mlle Eli Magnussen, directrice des Infirmières du Service National de Santé du Danemark, rencontre les directeurs des services de santé et les directrices des infirmières hygiénistes de Montréal. Des renseignements furent donnés à Mlle Magnussen sur la situation des infirmières au Canada. Après sept mois passés dans un camp de concentration Mlle Magnussen dit que c'est une expérience intéressante. Son courage révèle une forte personnalité.

RAPPORTS DES SECTIONS

Section du Nursing Général: La situation révèle que l'on manque d'infirmières pour le service privé et le service général dans les hôpitaux, les demandes sont plus nombreuses, les inscriptions sur les régistres sont moindres. Il y a moins d'infirmières qui prennent des positions dans les bureaux de médecins. Dans plusieurs provinces l'on étudie des tarifs et les heures de travail afin qu'il y ait plus d'uniformité dans les provinces. Des cours ont été donnés dans toutes les provinces. Des bibliothèques ont été organisées.

Section des Hôpitaux et des Ecoles d'Infirmières: Durant la prochaine période de deux ans l'on essavera de mettre à l'exécution les projets suivants: (1) Etablir une nomenclature des différentes positions qu'occupe l'infirmière à l'hôpital et définir ces positions. (2) Analyser, décrire le travail de l'infirmière à l'hôpital, en déterminer les spécialités dans le but de renseigner les administrations d'hôpitaux, les directeurs du personnel dans le choix et le placement des infirmières. (3) Une série d'articles sur les relations entre infirmières et l'hôpital seront publiés dans le Canadian Nurse dans la Page réservée à notre section. Le plan général de ces articles sera sous la direction du comité national; les articles seront le fruit des sections provinciales sous la conduite de la convocatrice du comité de publication.

RAPPORTS DES COMITÉS

Fonds de Secours pour les Infirmières de Grande-Bretagne: Le comité a fait les recommendations suivantes: (1) Que ces fonds de secours soit continué et que les associations provinciales soient avisées que les besoins sont encore grands. (2) La situation alimentaire en Hollande est bien améliorée; au contraire en Grande-Bretagne la situation est pire que jamais. (3) Que l'assistance financière aux infirmières de Grande-Bretagne soit continuée durant au moins une autre année afin d'aider l'établissement des maisons de repos pour recevoir les infirmières infirmes et malades à la suite de la guerre. Il est suggéré de recommander, en envoyant de l'argent, de l'employer pour aider personnellement les infirmières, qui ne peuvent plus travailler. (4) En Hollande le matériel d'enseignement semble manquer le plus. Comme il est impossible de se procurer ces choses au pays et qu'il est interdit d'envoyer de l'argent à

l'étranger, la situation reste difficile. A cause de cette même restriction financière il sera impossible aux déléguées de Hollande d'assister au congrès international. Il est suggéré que les infirmières du Canada leur viennent en aide.

A une assemblée du conseil de l'A.I.C. il fut suggéré d'informer les associations provinciales des besoins des infirmières d'Europe: (1) Pour les maisons de repos des infirmières de Grande-Bretagne, des ouvrages d'artisanat tel que: tapis crochetés, couvre-lits, étoffe du pays, etc. De l'argent qui permettrait d'acheter au Canada des cretonnes, des rideaux qu'il est impossible d'acheter en Angleterre sans coupons. (2) Que les colis alimentaires soient envoyés en Grande-Bretagne. (3) Que l'on considère l'achat de matériel d'enseignement pour les écoles de Hollande.

La résolution suivante fut adoptée à l'unanimité par le conseil à savoir: "Que les associations provinciales soient avisées de ces besoins, que les associations provinciales avisent le Bureau National s'il leur est possible d'aider financièrement une infirmière d'Europe afin qu'elle puisse assister au congrès international."

Comité des Relations Ouvrières: La convocatrice fait le rapport suivant:

En Saskatchewan une entente a été convenue entre les autorités des écoles d'infirmières, l'Association des Infirmières Enregistrées, et la commission du salaire minimum concernant le salaire des infirmières étudiantes.

En Colombie Britannique un comité spécial des relations du travail a été nommé pour aider les infirmières dans leurs problèmes, pour prendre part aux entrevues entre les infirmières et leurs employeurs et, si nécessaire, pour agir comme agent négociateur. Un certificat a été accordé par le Ministère du Travail de la C.B. pour négocier pour un hôpital. Trois représentants de l'hôpital et trois membres du comité spécial des relations du travail négocieront.

En Ontario, l'Association des Infirmières Enregistrées à décidé d'avoir un conseiller qui aidera les infirmières dans les difficultés qui peuvent survenir entre elles et leurs employeurs.

Comité de Législation: La Constitution et les Règlements, ainsi que les amendements proposés lors de l'assemblée générale du 4 juillet 1946, furent soumis aux associations provinciales avec une lettre contenant les résolutions qui ont parues dans le Canadian Nurse, sept. 1946, page 798. La convocatrice après avoir consulté le conseiller légal sur la façon dont l'A.I.C. devra opéré durant la période de transition s'étendant du 15 nov. 1946 à la prochaine réunion générale en 1948 rapporte que:

- 1. Une troisième vice-présidente doit être nommée. Mlle M. Myers de St-Jean, N.B., fut nommée en décembre 1946.
- 2. Que cinq représentantes des religieuses hospitalières soient nommées par le conseil. Les personnes suivantes furent nommées: Rév. Soeur M. Béatrice, N. S.; Rev. Soeur Columkille, B.C.; Rev. Soeur Ste-Gertrude. Qué.; Rév. Soeur M. Kathleen, Ont.; Rev, Soeur Irène, Sask.
- 3. La convocatrice du Comité de Législation et la convocatrice des Relations du Travail, Mlles Flanagan et K. Connor, deviennent membres du conseil.
- 4. Deux autres membres fassent partie du sous-comité. Rév. Soeur D. Clermont, Man., et Mme D. Harrison, Sask., furent nommées.
- 5. Les convocatrices suivantes soient nommées par le conseil: Comité du programme, Mlle R. Chittick; comité d'organisation, Mme McNaughton; comité des élèves infirmières, Mlle Waugh; comité de nomination, Mlle Mathewson.
- 6. Contribution: Qu'une contribution d'un dollar, per capita, soit remise par chaque association provinciale à l'Association des Infirmières du Canada. La dernière remise des contributions pour 1946 devra être faite en janvier 1947 afin de préparer la liste des membres.
- 7. Afin de se conformer à la résolution adoptée à l'assemblée générale demandant l'incorporation, le conseil de l'A.I.C. recommanda que le conseiller légal fut prié de procéder à l'incorporation.
- 8. De joindre la dernière clause de l'article VII, section 7, des règlements à l'article VII, section 1, qui doit se lire comme suite: "Sur toutes les questions qui ont été précédemment soumises à l'Association, les personnes ayant droit de vote à toutes les assemblées générales ou spéciales de l'Association, seront les déléguées provinciales ayant reçu leur mandat de vote. Sur toutes les autres questions qui n'intéressent pas la politique de l'Association, tous les membres peuvent proposer, seconder et voter selon le mode prescrit par la présidente de l'assemblée."
- 9. Que le nom de convocatrice des trois sections nationales soit changé en celui de

présidente des trois comités nationaux.

Comité National de Publicité: Après avoir constaté que d'autres feuillets sur les diverses activités des infirmières étaient nécessaires il fut recommandé:

- 1. (a) De prendre immédiatement les mesures nécessaires pour préparer des feuillets sur le nursing en hygiène publique, dans le but d'éclairer les infirmières qui désirent se diriger vers cette spécialité—donner la durée du cours, sa valeur, les positions offertes, insister sur les devoirs à remplir, les qualifications requises plutôt que sur les heures de travail et les salaires, etc. (b) Que la publication de feuillets sur le nursing en industrie, en orthopédie, et en pédiatrie soit la première chose au programme du comité.
- 2. La question se posa: Comment défrayer le coût de ces publications? Il fut recommandé d'essayer d'avoir de l'aide des compagnies d'assurance, d'industries et compagnies pharmaceutiques, et de permettre à ceux qui nous aiderons de faire une annonce discrète sur ces feuillets.

Le conseil approuva cette recommendation et demande que le texte de ces seuillets soit soumis aux secrétaires des associations provinciales et approuvé avant d'être publié.

REMERCIEMENTS

Des lettres venant d'infirmières de Grèce furent reçues au Secrétariat. Elles remercient les personnes qui leur ont envoyé des chaussures et des bas. Mlle Goodall, du Collège Royal des Infirmières, remercie également les personnes qui ont envoyé des colis d'aliments.

Caesarean Section

Caesarean Section was originally employed as a post-mortem measure. The Lex Regia of the Romans laid down that no pregnant woman should be buried undelivered. It was essential, therefore, that the baby should be removed before the mother's burial—and as this was a law introduced by the Caesars, the operation became known as the Caesarean Operation or Caesarean Section. The old legend that the name was derived from the fact that Julius Caesar was delivered by this operation is entirely erroneous. His mother long survived his birth as is proved by the fact that he frequently wrote letters to her while campaigning in Gaul.

Interesting People

Dorothy May Percy, R.R.C., has been appointed to head up a new division of nursing service under the Department of National Health and Welfare. She will be responsible for the nursing activities organized for the benefit of civil servants in Ottawa and throughout the Dominion.

Born and educated in Ottawa, Miss Percy graduated from the Toronto General Hospital in 1924. She qualified in public health nursing at the University of Toronto the following year and worked for a short time in Montreal. She returned to institutional work for a year as head nurse on the medical ward at the Ottawa Civic Hospital and then joined the National Office staff of the Victorian Order of Nurses for Canada as junior assistant superintendent. Seven years later, Miss Percy was appointed to the teaching faculty of the University of Toronto School of Nursing.

In 1941, Miss Percy enlisted with the R.C.A.M.C. After a year at Camp Borden Military Hospital, she proceeded overseas and was attached to No. 1 and No. 9 Canadian General Hospitals in Great Britain. Soon after her return to Canada in 1944, Miss Percy was appointed matron of the Petawawa Military Hospital. Upon her release from the Services, Miss Percy accepted a post as

John Steele

DOROTHY M. PERCY

executive secretary of the Division on Health of the Welfare Council of Toronto.

Miss Percy has served as chairman of District 8, R.N.A.O., as second vice-president of the R.N.A.O., and as president of the alumnae association of the Toronto General Hospital. She is a member of the Nursing Sisters' Association and of the Soroptimist Club.

Canadian nurses will watch with interest the development of this new federal health agency to which Miss Percy brings her years of experience and leadership.

Madeline Taylor has assumed the responsibilities of chief nurse in charge of the UNRRA nursing activities in the American Zone in Germany. Miss Taylor was the first Canadian nurse to be discharged from the R.C.A.M.C. to join UNRRA in 1945.

Graduating from the Montreal General Hospital in 1924, Miss Taylor engaged in private duty nursing for a year and a half before joining the staff of the Montreal branch of the Victorian Order of Nurses. In 1928, she was the recipient of the Mildred Forbes Scholarship from M.G.H. and enrolled in the certificate course in public health nursing at the McGill School for Graduate Nurses. Returning to the V.O.N. Miss Taylor initiated a new service in Regina where she remained for two years. After a



Max Gragge

MADELINE TAYLOR

brief period with the Edmonton branch, she returned to the Montreal branch as supervisor for nine years.

Miss Taylor joined the R.C.A.M.C. in 1940, going overseas in June of the tollowing year. She was among the group of nursing sisters aboard the troopship which was torpedoed en route to Italy in 1944. On returning to Britain, she was attached to No. 22 Canadian General Hospital with the special job of instructing recruits from the replacement units in their duties as orderlies.

Miss Taylor went to Germany with UNRRA in 1945, rising rapidly from team nurse to supervisor. With the re-organization of UNRRA last autumn, she was given the supervision of all of the teams in Bavaria. Her new duties were commenced the first of January this year.

Elizabeth E. Copeland is now supervisor of Unit 3 of the Metropolitan Health Committee in Vancouver.

Prior to entering the school of nursing of the Royal Jubilee Hospital, Victoria, to commence her training, Miss Copeland had secured her licence as a pharmacist in British Columbia. She gave up one form of salesmanship to enter another when she enrolled in the public health nursing course at the University of British Columbia. In 1938 she became school nurse in West Vancouver where she remained until she served as acting supervisor of the North Vancouver Health Unit, 1944-45. Miss Copeland further qualified herself in supervision and administration at the McGill School for Graduate Nurses in 1946.

Miss Copeland has always been intensely interested in young people's work. She has had a wide experience with girls' summer camps serving in almost every capacity—counsellor, business manager, nurse, director. She is ardently interested in music, art, and spends many a pleasant hour in rambles through the woods gathering leaves and blossoms for floral arrangements. Pharmacy's loss was nursing's gain!

Lila M. Baird, who has been office manager and secretary-treasurer of the Public General Hospital, Chatham, Ont., for the past twenty-three years, has retired. Miss Baird has also been assistant administrator for the past ten years and has a fine record as a valuable asset to the nursing staff of the hospital.



ELIZABETH COPELAND

Miss Baird received her high school education and business training in Ridgetown, Ont. For eight years she worked as billing clerk with a large wholesale firm, entering the Public General Hospital School of Nursing in 1914. She engaged in private duty nursing for several years before entering the business end of hospital management. While her official resignation has been ac-



Ross Hickin, Chatham

LILA BAIRD

cepted, Miss Baird has generously consented to continue with part-time work at the hospital until the general staff shortage has been relieved.

Miss Baird has been feted by the hospital board and medical staff in tribute to her "long, conscientious, capable and outstanding service as a member of the hospital staff."

Miss Baird has numerous hobbies to turn to when her professional activities are terminated. She loves puttering about in her garden, especially caring for her flowers. Stamp-collecting engrosses her interest with needlework for a side-line. We join her associates in wishing Miss Baird many years of happy enjoyment.

Margaret Motherwell, who has been superintendent of the British Columbia Provincial Infirmaries in Vancouver since 1936, has retired. During her ten years in this capacity, Miss Motherwell transformed the internal organization of the Infirmaries

and replaced the previous hopeless outlook of the patients with one of useful satisfaction. Her efforts have resulted in attention being focused on the plight of the chronically ill persons. She raised the standards of care and nursing practice to a very high level.

F. Isobel McEwen, who has been director of the Outpost Hospital Department of the Red Cross Society in Ontario, has retired. Born and educated in Perth, Ont., Miss McEwen graduated from the New York Post-Graduate Medical School and Hospital. She served overseas with the Canadian Army Medical Corps in World War I and on her discharge joined the staff of the Ontario Health Department. In 1927, she left that work to enter Red Cross work as director of the Toronto Junior Branch, transferring later to her recent work. In her capacity as superintendent of the field nursing staff, Miss McEwen directed thirty-one hospitals located all across the Province of Ontario.

Fingernail Care

Fingernails reveal many things to the experienced eye of the physician.

Writing in *Hygeia*, Dr. Everett T. Duncan states: "Physicians often glean some indications of unusual or abnormal tendencies of a patient by inspecting the nails. Notice the closely bitten nails and bulbous fingers of people afflicted with heart ailments or chronic lung disease; the traverse ridges prominent after a severe illness such as scarlet fever; the pitting of the nails in psoriasis; the color changes and undermining of the plate in fungous infections, and the brittleness and separation from various causes."

Dr. Duncan makes the following suggestions for nail care:

"White spots, or, in medical parlance leukonychia, are due to air in the nail substance resulting, perhaps, from too vigorous pushing back of the nail base in manicuring or other minor injuries. Total whiteness of the nail is rare and may be hereditary or the aftermath of severe toxic conditions. Treat-

ment consists of avoiding such rough pressure as might occur from using an orangewood stick. An advisable form of cuticle care for one susceptible to this condition is to wipe the borders of the soft tissues with an oiled damp cloth while they are soft.

"Brittleness of the nails may be congenital or acquired. Suggested causes are mild, repeated trauma as in typing, vitamin A deficiency, or the use of nail polish removers containing acetone. Today, buffing with an abrasive is not used as formerly. Files or emery boards should be avoided to prevent aggravation of a splitting or peeling tendency. In these cases the nail should be clipped behind the split area.

"Nails cannot be nourished from without, but daily applications of a bland oil may prevent brittleness when the condition is not due to an infection. Oil cannot strengthen the nails. Excessive immersion of the hands in soap and water is to be avoided in cases of soft nails."

To make the most of dull hours; to make the best of dull people; to like a poor jest better than none; to wear the threadbare coat like a gentleman; to be out-voted with a smile; to hitch your wagon to the old horse if no star is handy — that is wholesome philosophy.—BLISS PERRY

Educational Policy

Contributed by the Committee on Educational Policy of the Canadian Nurses' Association

Committee Functions

The former Committee on Nursing Education has been redefined in the recently accepted Constitution and By-laws of the Canadian Nurses' Association and is now known as the Committee on Educational Policy with the following functions:

(a) To formulate policies for recommendation to the Executive Committee in regard to nursing education, both graduate and undergraduate, which will assist the nursing profession to meet the changing demands in respect to nursing service.

(b) To assume direction for studies or demonstrations required to implement any change in policy recommended by the Executive Committee.

There are two sub-committees under this committee at the present time: (1) male nurse education; (2) subsidiary nursing workers.

The membership of the Committee on Educational Policy is as follows:

Chairman, A. J. Macleod, Department of Veterans Affairs, Ottawa; vice-chairman, M. Mathewson, superintendent of nurses, Montreal General Hospital; secretary, E. G. Young, superintendent of nurses, Ottawa Civic Hospital. Members: N. D. Fidler, University of Toronto School of Nursing; Sr. D. Clermont, chairman, Committee on Institutional Nursing, St. Boniface Hospital, Man.; H. Carpenter, Public Health Division, York Co., Ont.; M. Myers, instructress, Saint John General Hospital, N.B.; K. W. Ellis, president, Provisional Council of University Schools and Departments of Nursing; G. M. Hall, general secretary, C.N.A

Acting with the consent of the Executive Committee, two more members have been requested in order to have advice on publicity and a convener for the sub-committee on subsidiary nursing workers.

Demonstration School Administration Committee

This committee, by virtue of its second function as laid down in the By-laws referred to above, was the one chosen to represent the C.N.A. on a Joint Committee with Red Cross representatives, to function as the Demonstration School Administration Committee. The three representatives of the Canadian Red Cross Society on this Joint Committee are: F. W. Routley, M.D., National Commissioner; E. K. Russell, chairman, Nursing Committee; H. McArthur, director of Nursing Service.

The first announcement, concerning the very generous help which the Canadian Red Cross Society has agreed to give the Canadian Nurses' Association for the demonstration of an Independent School of Nursing, appeared in The Canadian Nurse on page 22 of the January, 1947, issue, under "Epoch-Making News." In the meantime a sub-committee had been appointed to review suggestions from the provincial nurses' associations of names of hospitals which might prove suitable for the location of the Demonstration School, and nurses to fill the position of director of the school.

The sub-committee met in Montreal on January 15, 1947, and reviewed the suggestions made from the provinces. On the whole, the sub-committee was disappointed that so few hospital schools were considered suitable sites for the experiment; the number of nurse educators, on the other hand, who were suggested as possibilities for the position of director, was quite encouraging. The recommendations of this sub-committee were presented to the Demonstration School Administration Committee on

MARCH, 1947

January 27, 1947. Following this meeting the first Canadian Press release was made by the president of the Canadian Nurses' Association and appeared in local papers.

Certain hospitals are being approached and it is hoped that by the

next issue of *The Canadian Nurse* the Canadian Nurses' Association will be able to announce where the demonstration will be undertaken as well as the name of the director for the school. You will be kept informed through this Page of the development.

Obituaries

Yvonne Baudry, who was the first nurse to graduate in 1901 from old St. Luke's General Hospital, Ottawa, died recently in her seventy-second year following a lengthy illness. For six years after she graduated, Miss Baudry was in charge of the scarlet fever ward of the Strathcona Hospital, Ottawa. During the next six years she was in charge of the quarantine section of the Gros Isle Hospital, Montreal. She served as matron of the Canadian Laval Hospital in France for four years during World War I. On her discharge from the C.A.M.C., Miss Baudry joined the Dominion Bureau of Statistics from which she retired in 1939.

Ella Betts, who graduated from the Saint John General Hospital in 1895, died recently in Saint John, N.B. Though Miss Betts retired from active nursing some time ago after having served as matron of the Home for Incurables in Saint John, and in private duty in New York, she always maintained a lively interest in professional activities.

Sarah Fraser, who graduated from the Montreal General Hospital in 1904, died suddenly in Renfrew, Ont., at the age of eighty. Miss Fraser engaged in private duty for a considerable part of her professional career. For a time she was on the staff of the Children's Memorial Hospital, Montreal. She was active in her alumnae association. Miss Fraser retired in 1930.

Mrs. Frances (Pollard) McLain died recently at the age of eighty-five. Born in Ingersoll, Ont., Mrs. McLain taught in Ontario for some years before entering a school of nursing in Philadelphia. During the Spanish-American War, she enlisted with the United States Army, serving in Florida and Cuba. After nursing in Detroit for many years, Mrs. McLain operated a private hospital in Windsor, Ont.

Lila Jennings Miller, who graduated from the old Western Hospital, Montreal, died recently in Bladworth, Sask. Miss Miller worked for a number of years in Davidson, Sask., and had served with the Victorian Order of Nurses in Ottawa and Edmonton prior to her retirement. She had maintained an interest in her professional organization and was always willing to give a helping hand in an emergency.

Mrs. Ethel C. (Smith) Moulds, a graduate of St. Luke's General Hospital, Ottawa, died recently in Ottawa following a short illness. Mrs. Moulds had worked in western Canada with the Victorian Order of Nurses and had been superintendent of the hospital at High River, Alta., and later at Swan River, Man.

Mabel Ryan, who graduated in Kingston, Ont., and later practised in New York, died suddenly in Smiths Falls, Ont., where she had resided since her retirement several years ago.

Lillian Tobin, who graduated in 1928 from the Ottawa General Hospital, died recently in Toronto. After several years on the staff of Strathcona Hospital, Miss Tobin enggged in private nursing in Ottawa. Early in 1946, she joined the staff of the Peterborough Veterans' Hospital.

Preview

The second of our series of articles on nutrition is aimed particularly at the public health nurse. What are the most effective ways of disseminating information about nutrition to the families in our communities? Mrs. H. Ruth Crawford, of the Department of Public Health Nutrition at the University of Toronto, maps out definite plans for the public health nurse to follow.

Nursing in China

L. CLARA PRESTON

THE EVOLUTION of nursing work in China has been amazing to those of us who have been privileged to see it so quickly and efficiently taken over by the Chinese nurses. When I went to Changte, N. Honan, China, twentyfour years ago, our hospital consisted of a chapel, dispensary, operatingroom, and private and public patients' rooms, built around courtyards, in true Chinese fashion. The patients slept on brick platforms, "Kang" in Chinese. These were covered with straw matting. At night they spread their padded quilt, which served as a mattress, rested their heads on a wooden or hard pillow. and covered themselves with another clean or dirty quilt. If the patient was a bed patient, they would have their beds made with hospital sheets, quilt, and pillow.

There was an outdoor kitchen. The patients supplied their own food and coal. This had its advantages and disadvantages. The food could be what the patient wanted, not what the doctor ordered. It was the cause of a great deal of friction among the patients when others took their coal or when all of the fires were being used, and they could not cook their

food.

The assistants were mostly young widows or girls, locally trained, who became very useful and helped in every department. One was always on call at night or for outside obstetrical calls.

The vard and toilets outside were taken care of by a poorer type of woman. The scavenger came twice a day and paid the hospital a monthly sum for the privilege of carrying away our "night soil" for their gardens.

This type of hospital had some advantages. The patients felt more at home, it was easier for the women to finance, it took less administration. and gave the staff more time to teach

the patients how to read and to give lessons in hygiene. It was amazing the number of cures and the results

we had in spite of conditions.

The doctors looked forward to the time when their patients could have 24-hour nursing care, post-operative supervision, and suitable diets. When orders could be given to the head nurse with the knowledge that they would be carried out, a step forward had been taken.

When new modern hospitals were built to meet the need of the community, painstaking details had to be thought out by the builder, doctor, and nurse, and careful record of supplies kept. There was no modern machinery for cutting wood. This was done by hand and the wood was seasoned, not always successfully, by the sun. Bricks were contracted for and brought to us by wheelbarrows. Inside paint was all put on by the use of silk waste and rubbed in by hand. We were fortunate in having good carpenters, painters, tinsmiths, and masons and we were very grateful for their co-operation.

Equipping the hospital was by trial and error method. A back-rest. bedside table and stool, mattress, cradle, baby's bassinet, electrical baker all seemed so simple as we used them every day in our training days. The Chinese have a proverb, "To look at a thing is easy but to do it is hard.' That was the same, we found, in getting our equipment. We had to give our ideas to the workmen, in Chinese, often without proper dimensions. These things were all new to the Chinese but once a pattern was established it was easy.

To find the right kind of student with a fine Christian character, three

years of high school, with enough financial backing and a desire to learn nursing was not easy. These were the nurses to pave the way and the future of nursing would depend much on

MARCH, 1947

these pioneers. Teaching had to be planned as the doctors and teachers had time and text-books were secured. The students were taught in Chinese.

When our first pupil nurses started their training there was no running water, no electric light. They worked 12-hour duty in a 4-year course with no previous knowledge of what nursing was all about. A mission central training school for six months was started at Weihwei. When they returned to us they had to take a good deal of responsibility. The oldest nurse went right on night duty with no night supervision but with a doctor or nurse on call if needed. One advance has been made after another and from 1931 to 1937 our work went along like a story book. Our out-patient department was opened, wards were equipped and staffed, a power plant was built giving us electric light and running water, x-ray, and electrical equipment in the laundry. Trained technicians arrived for the dispensary and laboratory and we were presented with a motor car for our village public health work. Each year our students became more helpful under the supervision of two good Chinese nurses and after four years of hard work our first three students graduated. They were the first graduate nurses to pioneer the way in our city of Changte, three thousand years old. What a thrill!

The Nurses' Association of China has an unique history. They translated and prepared text-books, set examinations, acted as a placement bureau for graduates, edited a nursing journal, and looked after the biennial nurses' meetings for China. Miss Cora Simpson travelled to the cities and into the remotest parts of China to encourage and help the nursing schools. She has written a book on

her experiences.

Now the student nurses are under the Department of Education of the National Government and the graduate nurses under the Department of Health at Nanking. The nurses' association is still functioning, happy that the government has taken over but still finding plenty to do.

Before I left North China in 1939 we had a fine District Nurses' Association organized. This was 'very interesting and helpful and we would have as many as twenty-five graduates attend. The N.A.C. was our placement bureau; we had graded salaries for nurses with experience or with post-graduate certificates. Postgraduate work was available in public health, obstetrics, dietetics, hospital administration, and fellowships obtainable from the Peking Union Medical College. Some of the larger universities offered degree courses in nursing.

The nurses' association was proud of the nurses registered to help in famine or war and many did excellent work for their country. The war has made many changes causing the closing of hospitals, destruction of buildings and equipment, training schools to be abandoned, pupils to flee to all parts of the country, working under the Japanese in the North and under constant bombings in the West and South. These bombings disorganized routine and interrupted class work, made emergency care a necessity.

In the west, the work was carried on in spite of difficulties. Schools took in refugee students from many other training schools, even if it did disorganize their classes, and carried on all through the war years. The government conscripted the new graduate nurses. The local hospital could keep 15 per cent of the graduates; the others were sent to the Red Cross hospitals, public health centres, or into military work, wherever there was the greatest need. Our nurses just accepted this and chose lots where they would go.

Now that the war is over the picture changes again. The difficulties seem insurmountable—rehabilitating hospitals, reorganizing competent staffs, getting equipment, inflation, civil war, famine, thousands suffering from tuberculosis and malnutrition. In addition there are outbreaks of epidemics occurring all over the country, besides the ordinary illnesses. These are some of the problems that

face the doctors and nurses.

STUDENT NURSES PAGE

An Answer to Evelyn

Editor's Note: The Student Nurses Page in the August, 1945, issue (page 647) carried a letter purportedly written from one student nurse to another. Now, a year and a half later, comes an answer to that letter. Some of the preliminary students of the Aberdeen Hospital, New Glasgow, N.S., who read Evelyn's letter with interest, have written an answer to it. This combined letter embodies a glimpse into the feelings and aspirations of four of the students.

Dear Evelvn:

You will never realize how grateful I am to you for writing me such an inspiring letter. It gave me courage to continue my training and to try to make a success of my career. It made such a difference to know that others have had their discouraged moments, too, yet have come out on top.

I have given your letter a great deal of thought and consideration. Because of your wise and frank advice, I can now see how wrong I was in my judgment of many things which have confronted me since my training started. I know now that my anxieties are not something I alone have experienced but are common to most student nurses. In the beginning we each had the same opportunity to grow and develop and profit by our experiences so I understand what you meant when you said that the various talents, personality traits, clothes, etc., of my classmates are factors to be taken in my stride.

You mentioned that the student nurse group tends to form itself into cliques. Perhaps I am especially lucky then for I have found that my classmates are very friendly and willing to help me. I admit that at first I found them rather distant but realize now it was only shyness. I have found that as we learn new and different things and work together, the task becomes less difficult.

When I first started, I found it very hard to buckle down and study. As you know, it is quite a while since I finished school and a person certainly does forget how to concentrate on textbooks. I would strongly advise any girl who was interested in nursing to keep up with some serious reading and study, even though she was working at some other job first. used to feel terribly discouraged and, but for your sound counsel, would probably have thrown up my training. Now I love my work and truly understand what you meant when you said that this is more than a career. This business of helping people who need me is my chosen life work. I know that I must learn to accept the bitter with the sweet, the rough-going with the smooth, the hard tasks with the easy. In fact, Evelyn, though I have not added any inches to my height, I think I have at last grown up.

When I first was assigned to a ward, I was excited and thrilled. Then, when I actually went on duty, I had the strangest and most nervous feeling. The place seemed too large and I felt as though everyone was eyeing this novice. When I saw the senior nurses hustling around so efficiently, I felt small and insignificant. I almost dropped the breakfast tray I was carrying. Looking back on those first

MARCH, 1947

few days, I have to chuckle at what a clumsy oaf I must have seemed to the patients. I can truly say that I look forward to my hours on the wards. Having more confidence, I don't make so many blunders.

I have firmly resolved to forget my personal feelings, and to regard my past unhappiness as part of the game. With renewed courage and faith in God I shall work for a bigger and better tomorrow and the full realization of my dreams.

Thank you again, Evelyn, for your help and inspiration. You have

proven a true friend.

Yours very gratefully, Elizabeth

A Home-Made Incubator

MARIAN COCHRAN

THERE is no condition of infancy which requires more specialized care and equipment than prematurity. At the Children's Memorial Hospital in Montreal, the condition of prematurity is usually complicated by infection or congenital abormalities as the normal infant would be cared for in the hospital where he was born.

Many improvised and commercial incubators are very satisfactory for uncomplicated prematurity, but frequently they are inconvenient or inadequate in cases where oxygen therapy or intravenous therapy are

indicated. We then conceived the idea of having an incubator built to our specifications, and have found the result highly satisfactory.

Our plan is an adaptation of the premature incubator used by the Massachusetts State Department of Health. It consists of a white enamelled wooden box, with sliding panels of shatter-proof glass on top and one side. Ventilation is provided by air vents across the top of box and lower sides. The bed is heated by a 40-watt Mazda lamp, separated from the mattress by a barrier of fine-mesh wire.



The incubator in operation

There is automatic thermostatic control, ensuring constant temperature. A metal container holds water for increasing the humidity. Oxygen, intravenous, and clysis therapy may be administered through the air vents.

We have used this bed not only for prematurity but for any infant under five pounds who is debilitated or in collapse. The thermostat is adjusted to maintain the desired heat in the incubator, varying from 85-95°. The infant is dressed according to his condition and his needs. If necessary he is placed in a premature jacket, covered with a light blanket, but he is never wrapped.

Dimensions of incubator: length, 30 inches; width, 17½ inches; depth,

15 inches.

Book Reviews

The Nurses Textbook of Anatomy and Physiology, by A. M. Spencer, M.B. 288 pages. Published by Faber & Faber Ltd. 24 Russell Sq., London, W.C. 1, England. 1946. Illustrated. Price 8s. 6d.

Reviewed by Sister Annunciata, Instructivess of Nurses, St. Elizabeth's Hospital, Humboldt, Sask.

The subject matter of this book is arranged in seven parts which follow in logical sequence. The first gives an outline of the body as a whole. The second part deals with the systems responsible for taking in the substances required by the tissues, and part three with the great transport system bringing these substances to the tissues. Part four describes the various tissues and the work they have to do. The next division is concerned with the organs of excretion and part six with the nervous and endocrine systems as controlling and co-ordinating the work of the various tissues. The final chapter discusses metabolism and concludes with miscellaneous questions and answers.

Each part is accompanied by an appreciable number of excellent illustrations which help to bring out important points, clarify details, impress the picture, and favor retention. The question and answer method used throughout the book helps students to answer questions correctly and at the same time emphasizes the important parts of the subject. The author has kept in mind the needs of the student nurse as he adheres to basic principles, avoiding all unnecessary detail. The table of contents and index make it easy to locate desired information.

A Summary of Medicine for Nurses, by

R. Gordon Cooke, M.D. 104 pages. Published by Faber & Faber Ltd., 24 Russell Sq., London W.C. 1, England. 1945. Price 3s. 6d.

Reviewed by Mary Stewart, Royal Alexandra Hospital, Edmonton, Alta.

This little book consists of concise statements of accepted facts of a few of the ordinary diseases with which nurses come in contact. The following is an example of the form in which the material is presented:

Anemia-agranulocytic. Condition. Severe reduction of white blood cells. Cause. May be unknown. May be secondary to certain (e.g., amidopyrine, sulphonamide group). Symptoms and signs. General weak-Ulceration of mouth and throat Hemorrhage. Treatment. Injection of pentnucleotide. Transfusions. Local treatment to mouth. Withdrawal of drug (if cause). May resemble. Leukemia, Vincent's angina. Special tests. Regular blood count if condition suspected as likely to arise. Sternal puncture. Blood picture. White count extremely low. Other points. May be rapidly fatal. Mild type may occur. May be due to an idiosyncrasy. Patients who recover warned against repetition of drug, if cause. Also called agranulocytic angina.

This text could be used by a young head nurse in her preparation for the "morning circle," or by public health nurses as a guide if they were stationed long distances from a doctor. This, in my opinion, would be the best uses for which this book would be of value.

The American Hospital, by E. H. L. Corwin, Ph.D. 226 pages. Published by

The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) \$1.50.

Reviewed by Margaret Tennant, Matron, Lady Minto Hospital, Melfort, Sask.

This is a most concise and detailed outline of problems and relationships pertinent to the American picture. However, we feel, especially in the latter units, that there may be many comparative aspects applicable in some measure to Canadian situations.

All phases of hospital work, from origin and development to finance and personnel, are most ably discussed. The writer has pointed out that acceptance by the public of hospital plans to provide security in illness has put hospitalization within reach of increased numbers. This, in turn, stimulated standardization of services and necessitated economy of time and effort. Hospitals are urged to develop and maintain educational public relationships. Increasing costs in the average modern hospital have been accelerated by the fact that today one-third of the floor space actually houses patients. As a direct reference to increasing costs Dr. Corwin cites per patient diem cost in a gynecological and obstetrical hospital in New York as increasing from \$1.00 per patient per day in 1857 to \$11.25 per patient per day in 1944. Canadian sources report 70-80 per cent increases in costs since 1939.

We feel that this will be a valuable reference for hospital libraries.

Textbook of Psychiatric Nursing, by Arthur P. Noyes, M.D. and Edith M. Haydon, A.M., R.N. 396 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 4th Ed. 1946. Price \$3.00.

Reviewed by Florence Thomas, Director of Nursing, Ontario Hospital, London.

The first three chapters sketch mental hygiene principles, physiology of the emotions and normal psychology. The second section (not divided in this way in the text) is given over to the discussion of various mental illnesses and emotional disturbances, with their nursing care. The final chapters give a survey of the principles of general nursing care, and a history of psychiatry and psychiatric nursing. It is unusual to find these following the care in specific illnesses. It would be interesting to know the reason of the authors for this method of presentation.

The clearly defined section headings within

each chapter, and the bibliography following each, are helpful for teaching and for reference, as well as for general reading.

This is not an elementary book, but its clarity and comprehensiveness should make it valuable to the new student, as well as to the person who comes to it with previous knowledge of the subject.

Nursing in Eye, Ear, Nose and Throat, by Abraham R. Hollender, M.Sc., M.D., and Maurice F. Snitman, M.B. (Tor.). 258 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St., W., Toronto 2B. 1946. Illustrated. Price \$3.75.

Reviewed by Elsie Denman, Supervisor, Eye, Ear, Nose and Throat Department, Montreal General Hospital.

This text has been prepared to give the nurse-in-training a theoretic knowledge of what the fields of ophthalmology and otolaryngology entail, and to familiarize her with the more important tasks she may be called upon to perform. "The qualifications for nursing of eye, ear, nose and throat patients are the same as those for nursing in This statement bears other specialties. emphasis, because it is commonly believed in certain quarters that most eye, ear, nose and throat diseases are of a minor nature and require very little training and experience to manage." The fallacy of this last statement has been pointed out in this book.

The chapters covering anatomy and physiology, as well as those diseases occurring in eye, ear, nose and throat, are complete and not too technical. The many very excellent illustrations are of much value in the study of this subject. The section on preparation for operation, post-operative nursing, and management of emergencies is highly recommended. A very complete glossary is found at the back of the book and is a valuable asset to student and supervisor alike.

Professional Adjustments in Nursing, for Senior Students and Graduates, by Eugenia K. Spalding, R.N., M.A. 509 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 3rd Ed. 1946. Illustrated. Price \$3.75.

Reviewed by Margaret Street, Supervisor, Royal Victoria Hospital, Montreal.

The third edition of this well-known textbook contains much new material and numerous revisions. While designed primarily as a source of information for senior students

regarding the personal and professional adjustments which the graduate nurse may have to make in the practice of her profession, the book in its present form is also an interesting commentary on present-day nursing which is viewed as the product of evolutionary changes within, and of sweeping social, economic, and political changes without the profession. It is nursing in the United States which is the chief object of analysis, and the status of the nurse and the fields of nursing open to her are discussed mainly in relation to that country. Yet both the international character of nursing and the similarity in nursing trends and developments between United States and Canada will make the material in this book interesting and helpful to Canadian student and graduate nurses.

The introduction deals with problem-solving as an essential in making professional adjustments, and discusses some of the essential requirements and sources of information in the solution of problems. Because of the fact that it is necessary for the graduate nurse to have some insight into the larger problems of the nursing profession as a whole before she can attempt successfully to solve her own professional problems, the author, in unit one, makes an analysis of the present-day social, economic, and professional status and problems of nursing.

Unit two makes a survey of occupational

opportunities for professional nurses, and outlines specific positions open to nurses. This unit also draws attention to the active interest which professional nurses are showing in the practical nurses, particularly with regard to the licensing of the latter, as well as to their place and function in the care of the sick.

The importance of continued education and professional growth for the graduate nurse, and sources of continued general and professional education are suggested. Guidance is given also as to procedure in choosing a field of work intelligently, and in securing, filling, and resigning from a position.

Unit three introduces the student nurse to the professional organizations in the United States, as well as to the International Council of Nurses. Brief reference is made to national nursing organizations in other countries. The relationship between nurses and their professional organizations is dealt with in a clear-cut manner.

Unit four is designed to assist the nurse "to understand some of the major issues and situations that will confront her in her search for social and economic security and in her striving for fine legal, personal, and professional relationships."

The comprehensive and up-to-date bibliographies appended to each chapter contribute materially to the potential value of this book.

Appointments - Transfers - Resignations

British Columbia

The following are the staff appointments to and resignations from the Metropolitan Health Committee, Vancouver, B.C.:

Appointments: Ruth Lane (B.A.Sc., University of British Columbia), Mrs. Otive Werenchuk (University of Toronto public health course), and Evelyn Hood (University Hospital, Edmonton, and University of Washington public health course) to Health Unit 4; Sally Martin (B.A.Sc., University of B.C.) to Burnaby; Mrs. Margaret Strongitharm to Richmond; Margaret Allport, on leave of absence attending University of B.C. where she obtained her B.A.Sc., has returned to the staff; Mrs. Isabelle Lyons (St. Paul's Hospital and University of B.C.), who is on

the B.C. Provincial Board of Health, is exchanging with Margaret Cammaert; Mrs. Elaine Sleath (B.Sc., University of Alberta); Margaret Steven (Vancouver General Hospital and University of B.C.), recently returned from the R.C.A.M.C.; Mrs. Jean Williams (B.Sc., University of Toronto), formerly with St. James health unit, Man.; Kathleen Oulion (Royal Victoria Hospital and McGill University), formerly with Outremont Health Department; Pauline Dobson (Vancouver General Hospital and University of B.C.); Rona Atkins (B.A.Sc., University of B.C.); Mrs. Vera Boe (Saskatoon City Hospital and University of B.C.); Mary McLaughlin (B.Sc., University of Toronto); Estelle Robinson (B.A.Sc., University of B.C.).

Resignations: Dorothy McKerracher

and O. Wright to take positions in Ontario; Marion Macdonell and Jenny Weir to attend Columbia University; Billy Williams and Mrs. Audrey Blanchard to attend University of B.C.; Grace White to attend McGill University; Eileen McKenzie, Miriam Coone, and Marie Walker to be married; Mrs. Anna Gunn.

Ontario

The following is information concerning the staff of the Ontario Public Health Nursing Service:

Appointments: Clare Connolly (Ottawa General Hospital and University of Toronto certificate course) to United Counties

health unit; Helen Elliott (Hamilton General Hospital and University of Toronto certificate course) as public health nurse with Ontario Agricultural College, Guelph; Nancy (Carroll) Robinson (University of Toronto diploma course) to Peel County health unit.

Resignations: Muriel Davis (Brantford General Hospital and University of Western Ontario certificate course) from St. Catharines-Lincoln health unit; Dorothy (Stone) Boswell (Brantford General Hospital and University of Toronto certificate course) from Oxford County health unit; Dorothy Hourd (Victoria Hospital, London, and University of Western Ontario certificate course) from Elgin-St. Thomas health unit.

Study Shows "Flu" Virus Exists in Several Forms

The influenza virus, an almost infinitesimally minute living particle, not only exists in several forms but these forms are quite different and individualistic, as if they were different species of animals. This is the conclusion of Dr. Jonas E. Salk of the University of Michigan. Determination of differences between strains is essential for preparation of more effective vaccines.

Since virus particles are too small to be seen, differences can be found only in their behavior in certain physiological and chemical tests. It has been recognized for some years that there are two major types—Influenza A and Influenza B. The maladies caused by these are indistinguishable so far as overt symptoms are concerned, but their immunological reactions are quite different. A vaccine prepared from A virus is of relatively little value in protecting a person from influenza caused by B virus. The vaccine used by the

United States Army is prepared from a mixture of both.

Dr. Salk's experiments show that within these two types there are highly individualistic strains. Since the flu viruses were first isolated, several continuous hereditary lines have been maintained at various laboratories. He tested some properties of these strains—especially a blood-agglutinating ability—under various degrees of heat. Heat tends to speed up chemical and physiological processes.

Like all other living things—it is assumed that the virus particle is living because it possesses the fundamental properties of life—those sub-cellular organisms seem bound by some fairly rigid law of heredity. Differences tend to become stabilized in families and persist. Techniques evolved for finding these differences promise to be of some value in preparing more effective vaccine.

-News Notes No. 51

Nursing Sisters' Association

At the annual meeting of the Montreal Unit the following officers were elected: President, Nancy Kennedy-Reid, R.R.C., matron, Ste. Anne's Hospital; vice-president, Hilda Henderson, matron, Queen Mary Hospital; secretary, Suzanne Giroux, R.R.C.; treasurer, P. Bisaillon; committee, M. Wright, E. Cumbers, M. deRosiers; visiting, Mrs. J. A. Foller.

Expression of Gratitude

The following paragraph is from a letter from the Matron-in-Chief, South African Military Nursing Service:

"I would like to take this opportunity of expressing my thanks and appreciation for the valuable service rendered by the Canadian nurses who served with the South African Military Nursing Service."—M. E. Story, Matron-in-Chief, S.A.M.N.S.



The Bayer Laboratories have been making "Aspirin" for over forty-six years.

To insure the quality, uniformity, purity and quick disintegration of "Aspirin" tablets, seventy different tests and inspections have been evolved.

All the experience, scientific knowhow and human ingenuity that go into the making of an "Aspirin" tablet produce an analgesic you can prescribe with confidence.

"ASPIRIN"

MARCH, 1947

News Notes

ALBERTA

EDMONTON:

At the annual meeting of Edmonton District, No. 7, A.A.R.N., Madeline McCulla was re-elected president. Jean Boyd will serve as recording secretary with Mary Bell as treasurer. Representatives to the Local Council of Women, Social Service Agency, and The Canadian Nurse, respectively, are Rita Ball, Miss Bietsch, and Violet Chapman. Following the annual reports, Mrs. Chester Gainer gave an interesting talk on "Parliamentary Procedure."

Royal Alexandra Hospital:

The annual meeting of the Royal Alexandra Hospital Alumnae Association was held recently, when the election of officers took place. Mrs. Norman Richardson will serve as president with Mrs. C. Douglas and D. Watt as vice-presidents. The secretaries are Mrs. W. Norquay and June Stuart. Jean Mackie will act as treasurer. Plans were made for the annual banquet, a bridge dance, and a bazaar. Miss Chapman, past president, showed a film on "Tuberculosis."

It has been announced that a scholarship of \$250 is available for post-graduate study to any nurse who is in good standing in this alumnae. Those interested should apply to Miss A. Anderson, convener, Scholarship Committee, Royal Alexandra Hospital,

Edmonton, Alta.

LAMONT:

Forty-three members and guests attended the annual meeting of the Lamont Public Hospital Alumnae Association when Mrs. A. Southworth was re-elected president. A toast to the Alma Mater was proposed by Mrs. M. A. Young and Mrs. Southworth responded. It was announced that a cash scholarship of \$250 will be offered this year in the interests of

promoting administrative nursing.

The guest speaker was Helen Meyers, superintendent of nurses at the hospital. She is a Vancouver General Hospital graduate and spent several years as a nurse with the R.C.A.F. and with the Northwest Staging route. She spoke on her work during those wartime years. K. Stewart, formerly a member of the Canadian Red Cross orthopedic unit overseas, told of the orthopedic and plastic surgery developments as undertaken by this unit during the war.

BRITISH COLUMBIA

KAMLOOPS:

The Kamloops-Tranquille Chapter, R.N.A.B.C., continues to work toward their goal of furnishing a room in the new wing of the Royal Inland Hospital. The sum of two dollars has been voted from each member to help cover the cost of furniture and drapes. Previous sums realized were

\$226 and \$125, the latter raised at a dance last fall. The amount required is approximately four hundred dollars.

MANITOBA

BRANDON:

Mrs. Peter McNabb Leitch was guest speaker at a meeting of the Brandon Graduate Nurses Association. She gave a talk on her experiences during the polio emergency in Los Angeles last year. Olive Thomas, the newly-appointed superintendent of nurses at the General Hospital, was introduced by Mrs. Selbie and welcomed to the meeting by Mrs. Perdue. A pleasant social evening was enjoyed with Margaret Gemmell's group in charge. Marjorie Trotter expressed the thanks of the members to the guest speaker.

NEW BRUNSWICK

CAMPBELLTON:

The Campbellton Chapter, N.B.A.R.N., was recently organized when the following officers were elected: President, Sr. Bujold, Hotel Dieu; vice-president, Mary Hubert, Soldiers Memorial Hospital; secretary, Mrs. Lena Sinnett; treasurer, Veronica Chulliner, H.D.; committee conveners: membership, Margaret Gillis, Tide Head; program and social, Ferne Hitchcock, S.M.H.; ways and means, Irene Chulliner, H.D.; hospital and school of nursing, Sr. Roy, H.D.; private duty, Mrs. I. Pettigrew; representative to The Canadian Nurse, Helen Wilson, S.M.H.

FREDERICTON:

Seventy-eight nurses were present at a dinner meeting of the Fredericton Chapter, N.B.A.R.N., when Margaret Kerr, editor of The Canadian Nurse, was guest speaker. An treesting lecture by Dr. Jean Webb, director of nutritional services, N.B. Department of Health, was the feature of a later meeting.

At the first meeting of 1947 it was reported that an electric record player and records had been given to the student nurses of Victoria Public Hospital as a Christmas gift from the chapter. Twenty-five dollars was voted towards the British Nurses Relief Fund and it was revealed that over 250 boxes of Christmas cards had been sold to raise chapter funds. The speaker of the evening was Dr. G. F. Vanwart whose topic was "Some of the Newer Drugs and their Uses."

Hilda Bartsch, who has been an active and valued member of the chapter and is leaving Fredericton, was presented with a gift. It has been learned that Mary Peters has arrived in China to take up her duties with an Anglican mission hospital. (See Interesting People. Dec. 1946 issue.) Kathleen Tait, after doing private duty here since her discharge from the R.C.A.M.C., has accepted a position with the D.V.A. at Christie St. Hospital,

Toronto.

Victoria Public Hospital:

Hilda Bartsch, who has served as superintendent for over two and a half years. recently resigned. Previous to her departure the medical staff entertained in her honour at dinner and presented her with an engraved silver tray. A suitable gift was also presented to her from the nursing and office staff. Evelyn Wood is at present acting superintendent. Rita Mahoney is in charge of the maternity ward.

MONCTON:

Mrs. Roberta Perry presided at a well-attended meeting of Moncton Chapter, N.B.A.R.N., when plans were made to send a box of clothing to a Dutch nurse. The guest speaker was Dr. Ian MacLennan, pathologist, whose topic was "The Rh Factor." This instructive address was also heard by the student nurses of the Moncton Hospital.

SAINT JOHN:

The annual meeting of the Saint John Chapter, N.B.A.R.N., was held at the Lan-caster D.V.A. Hospital with the acting presi-dent. Mary Downing, in the chair. Marion dent, Mary Downing, in the chair. Marion Myers, president, N.B.A.R.N., spoke on the C.N.A. Nurses' War Memorial which is to consist of the presentation of libraries to the nurses of the countries which were devastated by the war. The quota for New Brunswick is nine hundred dollars. A movie on "Blatis Surgery Processes" proved instructive and interesting to those present.

The election of officers resulted in Mary Downing as president with B. Selfridge and Mrs. E. Mooney as vice-presidents. The treasurer is F. Howard and B. Boulter will

serve as secretary.

A recent meeting of the Public Health Section, Saint John Chapter, N.B.A.R.N., took the form of a supper when fourteen members were present. Mary Flett was the guest speaker and her talk on "Canadian Literature" was very enjoyable. The regular monthly box to the overseas nurse was sent by Muriel Clarke.

Audrey McIntyre has joined the Saint John branch of the V.O.N.

General Hospital:

On her completion of twenty-five years' service as superintendent of nurses, Margaret Murdoch was presented with a pearl necklace and a beautiful bouquet by Mrs. Ralph Robertson, on behalf of the Board of Commission.

The senior division of the 1947 graduating class enjoyed a dinner party recently, their

last get-together before graduation.

A Bible study class is conducted once a week for students and graduates by Rev.

Mr. LeDrew Gardiner

Muriel MacConnell is spending a year in Vancouver where she is attending the Provincial Child Guidance Clinic. Hazel A. Tracey, formerly with the R.C.A.F., has rejoined the S.J.G.H. staff and is assistant supervisor, pediatric floor. Sara Cohen has resigned from



Floored by Floor Duty?

Gosh! What a relief. Uncomfortable shoes and floor duty just don't mix.

Research Shoes are scientifically lasted....built right on the inside where it's most important. Designed to leave ample room for that trouble maker, the fifth toe, they give natural support to every bone, muscle and nerve in the foot. So be foot happy, wear Research Shoes. Blachford Shoe Mfg. Co., 245 Carlaw Ave., Toronto 8.

Your local dealer's name on request.





Superior in Peptic Ulcer

KLIM Powdered Whole Milk, a more concentrated source of anti-peptic and antacid protein, is more effective in its neutralizing action.

By using KLIM, the 29 feedings of the standard procedure are reduced to 14.

Individual feedings of 1½ tablespoonfuls of KLIM in 3 ounces of water have a protein content of 3.3 grams in contrast to 2.6 grams in a standard milk and cream mixture. The milk curds are smaller, have a greater neutralizing effect, providing a larger quantity of the beneficial protein more effectively.

In addition, the associated minerals in KLIM exert a marked buffering action against gastric acids. With KLIM the mineral intake may be increased without adding appreciably to the dietary volume.

Consider these superior advantages in the treatment of peptic ulcers.

For professional information and literature write: The Borden Company, Limited, Spadina Crescent, Toronto 4, Ontario., Can.



First in preference the world over

the general duty staff. Mary MacDougall has flown to Portugal for further study of the Portuguese language.

St. Joseph's Hospital:

The following officers were recently elected by St. Joseph's Hospital Alumnae Association: President, Dorothy Giddens; secretary, Winifred Ruland; treasurer, Frances Dionne.

A recent fire completely destroyed the laundry with considerable loss to the hospital.

Sister Michael is welcomed back to the staff. Ethel Hogan and Rita McLeod are now at St. Michael's Hospital, Toronto. Morag Cuthbertson is residing in Montreal. Cecilia Markey is on the staff at Red Cross Hospital, Rexton.

St. Stephen:

Lois Mersereau, former night supervisor at the Chipman Memorial Hospital, who has retired, was voted an honorary member at a meeting of the alumnae association.

It has been decided to send a box of food to an English nurse every other month. Nellie Spinney is assembling the first box.

NOVA SCOTIA

GLACE BAY:

General Hospital:

Jean MacInnis is attending the University of Toronto School of Nursing taking a post-graduate course in teaching and supervision. Shirley Hull is also at that university taking the surgical supervision course. Florence Johnson is taking a course in pediatrics at Johns Hopkins Hospital, Baltimore.

St. Joseph's Hospital:

Eileen Gillis, having completed a course in obstetrical nursing at the Cornell Medical Centre, N.Y., is now on the staff of the King Edward VII Hospital, Bermuda. Sr. Anne Estelle has returned to the staff after completing a surgery course at St. Michael's Hospital, Toronto. The following nurses are doing post-graduate work: Margaret Dunn, B.Sc. in Nursing, St. Francis Xavier University, Antigonish; Grace MacEachern and Mildred Jessome, public health nursing, University of Ottawa; Gertrude Curtis, tuberculosis nursing, Tuberculosis Hospital, East Saint John, N.B.

NEW WATERFORD:

Vivian Cummings, of the General Hospital, is taking her BSc. in Nursing at St. Francis Xavier University.

SYDNEY:

City Hospital:

Francis DeKouchey, who has completed a teaching and supervision course at the University of Toronto School of Nursing, is now on the teaching staff. Kay MacKenzie is doing tuberculosis nursing at Trudeau Sanatorium, Saranac Lake, N.Y.



ONTARIO

DISTRICT 1

CHATHAM:

At the recent election of officers, held by the Public General Hospital Alumnae Association, Elsie Phillips was made president. Miss Phillips served with the R.C.A.M.C. in England, France, and Holland. Ethel Miller reviewed the activities of the past year. The treasurer, Dorothy Thomas, reported that \$100 had been donated to the Nurses' Education Loan Fund, \$25 to the Sick Children's Hospital, and \$35 to the Holland Nurse Relief Fund. The resignation of Annie Head as treasurer of the Plan for Hospital Care was accepted and Mrs. M. McDade was appointed in her place.

DISTRICTS 2 AND 3

There was a good attendance at the annual meeting of Districts 2 and 3, R.N.A.O., held at Guelph. Dr. H. D. Branion, of the Ontario Agricultural College, gave an interesting address on "Nutrition in Europe at the End of the War." Florence Walker, associate secretary, R.N.A.O., was also present and explained in detail many of the activities of the association. Marion Patterson reported on the R.N.A.O. annual meeting.

A skit, showing how volunteer workers may be used in the public health field, was put on by the Galt public health nurses, and an "Information Please" broadcast by the superintendents of the hospitals proved very profitable. Enjoyable solos were sung by Mrs. Rose Dillistone.

BRANTFORD:

In an effort to interest high school students in the nursing profession, an interesting project was recently put on by the Brantford General Hospital when 150 students were invited to make a tour of the hospital, the nurses' residence, bowl in the alleys, have supper at Winston Hall, and attend the "capping" ceremony of the probationers.

GALT:

Special speakers at meetings of the Galt Hospital Alumnae Association during the past year included: Helen Rush on V.O.N. work; Dr. John McNichol on medicine and treatment in overseas work during the war; Hilda Teather on "Military Nursing in Africa."

The first post-war annual reunion banquet was held last fall. Musical selections were rendered by A. Park and Mr. R. B. McMurdo. A tea and sale of work proved a successful means of raising funds for the furnishings of the office of the instructress in the new junior nurses' residence.

DISTRICT 4

FORT ERIE:

Sixty members were present at a dinner meeting of the Niagara Peninsula Chapter, District 4, R.N.A.O., when Catharine



LEEMING MILES CO. LTD.,

504 St.Lawrence Blvd., Montreal 1, Canada

REGISTRATION OF NURSES

Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on May 21, 22, and 23.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

A. M. MUNN, Reg. N.
Parliament Buildings, Toronto 2

O'Farrell, presided. Dr. J. Lowell Butters, the guest speaker, addressed the members on "Medical Services in Industry," interpreting the policies and duties concerning the nurse in such a service.

It was decided to discontinue sending parcels to Dutch nurses and consideration was given to the matter of sending needed articles to

British nurses.

HAMILTON:

General Hospital:

At a recent meeting of the Hamilton General Hospital Training School Alumnae Association, the Dr. Walter F. Langrill Education Fund was inaugurated. The purpose of the fund is to enable graduates to take refresher and post-graduate courses, and to participate in various projects which would further the objectives of their profession. Commemorating the long and devoted services of Dr. Langrill with the hospital and training school, the graduates were unanimous in choosing a name for the fund.

An interesting fact is that the nucleus of the fund came to the alumnae in the form of a legacy from the will of the sister of a graduate of the school, to be used for the benefit of nurses. A committee to administer the fund is to be appointed. Carolyn Finby, of Madison, Wis., was the patroness who left the legacy in memory of her sister, Vivian, who graduated from the training school in

1909 and died in 1922.

The Nurses' Christian Fellowship Group of the General Hospital sponsored a carol service in December for the student and staff nurses, with an attendance of 176. The program of carols, weaving through the Christmas story, included greetings, special music, poetry, and the description of Christmas from St. Luke. Catherine Nichol, Inter-Varsity Christian Fellowship staff member from Toronto, gave a fresh glimpse of Christmas by telling of a little boy's dream—a dream of what might have been had Christ not come. She told of the value of God's Christmas gift to us: Life, through Jesus Christ, His Son. Following the service the staff entertained the students with refreshments served around the tree.

St. Joseph's Hospital:

At a recent meeting of St. Joseph's Hospital Alumnae Association the election of officers took place with the result that F. O'Brien will now serve as president. B. Clohecy is secretary and A. Grace will act as treasurer.

The past president, Mrs. S. Hudecki, presented a cheque for one thousand dollars to Sister St. Edward, hospital superior. This money was raised by the alumnae in aid of the new hospital building. The first sod for this building was turned in March, 1945, but due to the shortage of labor and material progress has been halted. It is hoped that work will commence again in the near future.

WELLAND:

The December meeting of the Welland

Graduate Nurses' Association took the form of a Christmas party, with Miss Rossi as convener. Instead of exchanging gifts the members brought clothing to be sent to the children of the Rainy River Outpost Hospital and fifty cents was donated by everyone to purchase pyjamas and slippers. Mrs. Hill was in charge of the business meeting. The luncheon was served by Mrs. H. Beatty.

The election of officers took place at the first meeting of this year, with the following results: President, Mrs. G. Risk; vice-president, Mrs. R. Reilly; secretary, K. McNamara; treasurer, B. Clark. Plans were made to hold a "Country Fair" and sewing for the hospital room, maintained by the

association, was distributed.

DISTRICT 9

The following officers will serve for the Sudbury Chapter, District 9, R.N.A.O., during the coming months: Chairman, Mrs. W. Gray; secretary-treasurer, M. Desjardins; committees: membership, Mrs. J. Harmen; program, Z. Maloney; nurse education, M. McDonald; private duty, L. Langlois; publicity, W. Ahern; representatives to: public health, G. Motley; The Canadian Nurse, N. Shamess.

DISTRICT 10

The McKellar Hospital, Fort William, was the scene of the annual meeting of District 10, R.N.A.O., when Doris Shaw gave an account of the provincial annual meeting. Reports were received from the secretary-treasurer and chairmen of sections as follows:

Hospital and School of Nursing: Speakers featured at the various meetings included: Bessie Jackson, V.O.N., and instructors on "The Diabetic Patient"; Dr. J. D. Markham on "Drugs"; (Dr. Markham also gave a splendid lecture to the nursing staff of the McKellar Hospital on "Acute Cardiac and Pulmonary Conditions"); Dr. Ferguson on "Cardiac Conditions." The refresher course, arranged by the Thunder Bay Nurses' Registry, was well attended by members of this section, of which Doris Shaw is chairman.

Public Health: Highlights of meetings included the following speakers: M. F. MacRae, Fort William librarian, on "The Cult of the Best Sellers"; Edna Moore on "Health Units in Ontario." Three members of the group reviewed "Public Health Nursing in Canada" by Florence Emory and another feature was a "Quiz Program" on public health, locally and nationally, conducted by Vera Lovelace

and Agnes Baillie.

It was revealed that nineteen food parcels

were sent to Dutch nurses last year.

Bessie Jackson, former chairman of the Public Health Section, has the best wishes of everyone from the district in her new work at the Ottawa Civic Hospital.

PRINCE EDWARD ISLAND

At the quarterly meeting of the Prince

UNIVERSITY OF TORONTO SCHOOL OF NURSING

For the session 1947-48 the following courses are offered:

I. The Basic or General Course in Nursing: 5 years (47a calendar years) in length, leads to Degree of B.Sc.N. and gives also a qualification for general practice in public health nursing; qualifies fully for nurse registration. The candidate remains as a student in her University School throughout the entire course (with practice in the wards of the surrounding hospitals). The entrance requirement is senior matriculation (Ontario Grade XIII).

II. Courses for Graduate Nurses: One-year Certificate courses as follows:

Nursing Education: General (preparation for teaching).

Nursing Education and Administration: An advanced course.

Public Health Nursing: General.

Public Health Nursing: Advanced courses in Administration and Supervision, or other specialty.

Clinical Supervision in (a) Medicine. (b)
Surgery. (c) Obstetrics. (d) Paediatrics.
(e) Operating-room procedure. (f) Psychiatry or other specialty as selected.

Note: In Clinical Supervision the student chooses one of the above as her field of study for the entire year. The entrance requirement is junior matriculation (Ontario Grade XII).

III. A Special Arrangement for Graduate Nurses: Whereas a candidate with senior matriculation standing may register in the Faculty of Arts of this University and complete the Pass course in Arts in 3 years, and, whereas some of the sales to a 10th Pass course in Arts are identical with certain subjects included in the above Certificate courses, it has been arranged that a graduate nurse who registers in this Pass course in the Arts Faculty may register at the same time in this School and, during the same 3 years, cover the requirements for the Certificate in one of the courses as described above, except that the courses in Clinical Supervision are not inclined in the arrangement

For information and calendar apply to:

THE SECRETARY,
SCHOOL OF NURSING,
UNIVERSITY OF TORONTO,
TORONTO 5, ONT.



DERMATOLOGY FOR NURSES

By K. A. Boird

This book clarifies what has seemed in the past a hopelessly involved branch of medicine. "Schools of Nursing have been waiting for some time for a textbook on Dermatology that would describe and discuss briefly and concisely not only diseases of the skin, but in addition the many indications of disease and reactions of the body made manifest through the skin."— Marion Myers in the Foreword. Dr. K. A. Baird is a leading doctor in Saint John, New Brunswick, a lecturer at the School for Nurses, the Saint John General Hospital, and a member of the Hospital Medical Staff. - \$2.00

> THE RYERSON PRESS TORONTO

OPERATING-ROOM NURSE

required for

Coqualeetza Indian Hospital, 3 miles from Chilliwack, B.C.

Preference for experience in Chest Surgery. Salary: \$1,884 annum plus maintenance monthly in cash or kind.

Apply to:

Dr. W. S. Barclay,

Sardis, B.C.



CASH'S Loomwoven NAMES

Permanent, easy identification. Easily sewn on, or attached with No-So Cement. From dealers or CASH'S, 37 Grier St., Belleville, Ont.

CASH'S: 3 Doz. \$1.65: 9 Doz. \$2.75; NO-SO NAMES: 6 Doz. \$2.20: 12 Doz. \$3.30; 25e per tube

Edward Island Registered Nurses Association the special speakers included Anne Green, Health Educational Secretary, Canadian Tuberculosis Association, who gave an instructive address, and Mona Wilson, O.B.E., whose descriptive story, of her work with the Red Cross in Newfoundland during the war, was greatly enjoyed by the many members in attendance. A hearty welcome is extended to Miss Wilson who is now back in P.E.I.

Hattie McLaine is in charge of the new D.V.A. wing, P.E.I. Hospital. Stella Joy is back on the P.E.I. Hospital staff. Olive Dewar is with the Hot Springs Hospital, Banff, Alta., while Gladys Aitken, Hope Davey, Kathleen MacFarlane, and Stella MacLean are at the Westminster D.V.A. Hospital, London, Ont. Miss MacLean recently received her discharge from the army, after serving with the South African Military Nursing Service.

Mabel K. Holt, former superintendent of nurses at the Montreal General Hospital, has taken up residence in Charlottetown.

OUEBEC

Montreal Graduate Nurses' Association:

At the fifty-first annual meeting of the Montreal Graduate Nurses' Association, Effie Killins, director of the nursing registry, reported that the total number of calls filled by professional nurses for 1946 was 17.726. It was noted that, although this number was an increase of 3,000 calls over the previous year's activities, there is still a shortage of registered nurses for private duty. Total calls for non-professional workers were 3,261. The Argyle nurses are now on the call-board. There has been an increase in membership of 169. Elspeth Gruer, who was re-elected as president, told of aid given to nurses in Holland, to whom twenty-two boxes of supplies had been shipped.

QUEBEC CITY:

At a meeting of Jeffery Hale's Hospital Alumnae Association Brig. J. H. Price, O.B.E., M.C., who was a prisoner in Hong Kong, gave an interesting talk on "Life and Military Hospitals in Hong Kong."

A hearty welcome is extended to A. MacDonald and M. Jones who, after spending the past year in Edmonton, are back on the general duty staff. M. Jack is also helping out in this section. A. Grimmer is on the general duty staff of the Western Division, Montreal General Hospital, and E. Christensen and Mrs. J. Skinner are with the Alexandra Hospital, Montreal. D. Moores is at the Soldiers' Memorial Hospital, Campbellton, N.B. N/S M. Doddridge has been transferred to the staff of the military hospital in Winnipeg. V. Wrye, formerly with the R.C.A.M.C., is with the D.V.A. Hospital, Quebec City. M. Fitzgerald is taking a course in O. R. supervision and technique at the Toronto General Hospital.

SHERBROOKE:

Mary Todd was re-elected president of

VOLUME 43 NUMBER 4 MONTREAL APRIL 1947

THE CANADIAN NURSE



Eye Care by Dr. C. A. Thompson

Learning Activities by K. M. Stanton



Dandelion Four-O'Clocks

Photo by Munici Punds



OWNED AND PHBLISHED BY



When you say "USEFUL" hands, LISP!

KEEPING useful hands youthful is a problem, and nowhere is this truer than in the nursing profession. Passive, useless hands require a minimum of care. Active hands need active measures.

Counteract the innumerable washings necessary in any hospital and keep your hands soft, white and attractive by using 'Wellcome' BRAND Toilet Lanoline daily. Massaged gently into the hands every night and, used more sparingly, in the morning after washing, this soft, soothing cream will supplement the natural oils of the skin and give "on duty" hands that "off duty" look.

Tubes of two sizes at all reliable pharmacies.

MELLCOWE,

Toilet Lanoline



BURROUGHS WELLCOME

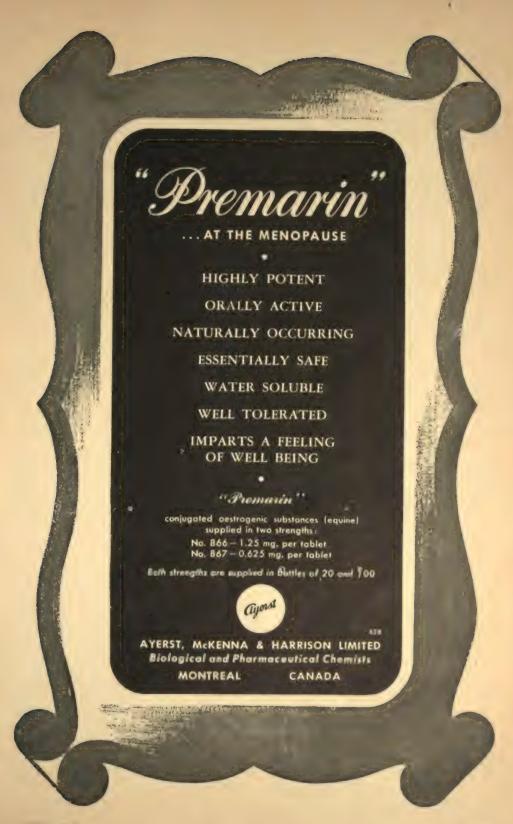
(The Wellcome Foundation Ltd.)
MONTREAL

For a generous free sample simply mail this card to P.O. Box 159, Montreal.

Please	send	me	a	free	sample	of	Wellcome	BRAND
Toilet .	Lanol	ine.						

Name.....

Address.



The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR APRIL, 1947

Manitoba's Watchtower	263
EVE CARE	266
NUTRITION EDUCATION AND THE PUBLIC HEALTH NURSE	270
LEARNING ACTIVITIES	274
It's Not the Patient It's the Visitors	277
SERVING HOSPITAL MEALS ATTRACTIVELY	279
BEDSIDE NURSING—An ESSENTIAL SERVICE	281
ENROLMENT IN UNIVERSITY SCHOOLS OF NURSING.	283
THE GERMAN NURSING SERVICES, 1945-46	285
PUBLIC HEALTH NURSING IN PRINCE EDWARD ISLAND	289
Personal Interview	293
LES SERVICES AUX MALADES	296
Interesting People.	298
Notes from National Office.	303
Notes du Secrétariat de l'A.I.C.	306
EDUCATIONAL POLICY	308
Modern Hosp tal Signaling.	309
An Exploratory Laparotomy	311
Book Reviews	313
Letters from Near and Far	315
News Notes.	319

Subscription Rate: \$2.00 per year — \$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) (hange of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.O.

250 Vol. 43 No. 4



BONE FLOUR, nature's own calcium and phosphorus is assimilable. Clinical tests show that pregnant mothers given bone meal have little or no dental caries, leg cramps... and the babies "whose mothers had been given bone meal had such long, silky hair and such long nails that the phenomenon was remarked

on by the nurses." From "Report on the Clinical Use of Bone Meal" by E. M. Martin, M.D., in the Canadian Medical Association Journal, Vol. 50.

The whole story of OSTEO-TABS cannot be told in this advertisement. Write today for Trial Package and Brochure... "Report on the Clinical Use of Bone Meal".

Fach enteric coated tablet represents:

Purified select Bone Flour.... 5 grs.
Ferrous Sulphate...... 5 grs.
Vitamin C.......... 25 mgms.
Vitamin D......... 500 int. units
Vitamin D........ 500 int. units
Vitamin B1 (Thiamin)... 75 mgm.
Vitamin B2 (Riboflavin)... 75 mgm.
There is no gastric irritation.



Reader's Guide

An active, progressive association is portrayed for us in the guest editorial which Beryl Seeman, president of the Manitoba Association of Registered Nurses, has prepared for this issue. It has not all been smooth going, for knotty problems persist in cropping up just when everything points to a clear road. Perhaps the wide horizons which characterize Manitoba have given the nurses length of vision for they seem to have found adequate solutions to most of the difficulties which Miss Seeman has described.

President Beryl Seeman is a Manitoban by birth. Following graduation from Yorkton Collegiate Institute, she entered the school of nursing of the Winnipeg General Hospital in 1932. She was awarded a scholarship by her hospital and took a post-graduate course in obstetrics and gynecology at the Royal Victoria Hospital, Montreal. After receiving her diploma in 1937, she continued on the staff there as a head nurse until 1939. Her next three years were spent in head nurse's duties at the Winnipeg General Hospital. In 1943, she took the course in teaching and supervision at the McGill School for Graduate Nurses. At present, Miss Seeman is clinical instructor in surgery and some of its specialties at W.G.H.

We are all familiar with the famous "seeing-eye dogs." They perform a wonderful task in guiding their blinded masters. But how much more valuable it would be to preserve the vision of seeing men and women! Every nurse who has the opportunity through careful treatment of apparently minor eye injuries to prevent possible blindness is rendering a service to humanity. Dr. Charles A. Thompson has made specific reference, in his discussion on the prevention of damage to the eyes, to the work of the industrial nurses. He delivered this address at a refresher course for that particular group sponsored by the University of Western Ontario in London. What he has to say may be applied with equal value to the work of every nurse, particularly those who see eye injuries in school children.

The second article on nutrition appears to be pointed specifically at public health nurses. Mrs. H. Ruth Crawford had this group in mind when she wrote it. But nurses engaged in hospital duties also have opportunities to give instruction to parents regarding the normal eating habits of children. Don't miss reading it! Mrs. Crawford is on the faculty of the Department of Public Health Nutrition, University of Toronto.

Still on the topic of food, Barbara Bell has some helpful advice on how to serve the meals in hospital. Most of these rules could be applied in the home with equal value. Until recently, Miss Bell was superintendent of the Plummer Memorial Hospital, Sault Ste. Marie, Ont.

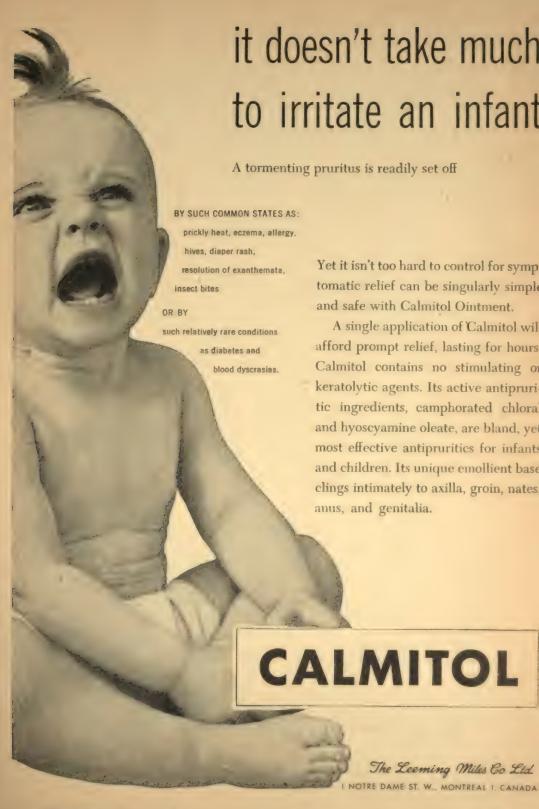
An exceedingly helpful companion article to the valuable discussion on teaching and learning, which appeared in the February issue, will be found in **Kathleen M. Stanton's** material. Miss Stanton was on the staff of the McGill School for Graduate Nurses prior to her sudden death in March, 1947.

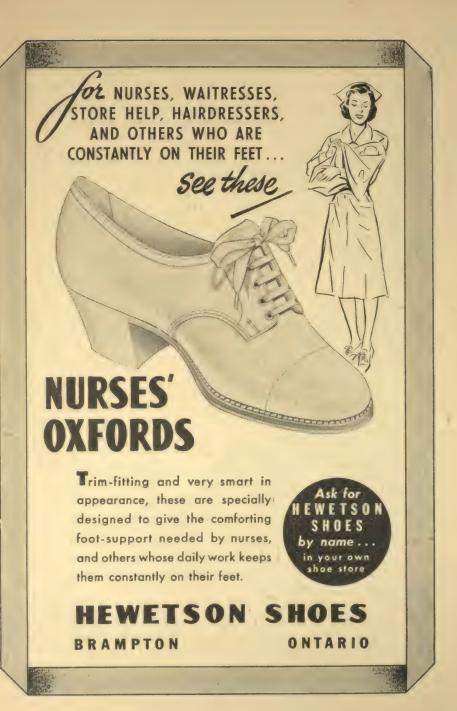
When a private duty nurse tells us about her patients, we are glad to listen. When we hear about her problems with the patient's visitors, we are all sympathy — visitors can be a source of pleasure but they also may be nuisances when they stay too long or bother the patient. Read the remedies which Nona Blake suggested to Louise Price Bell.

Christine E. Charter, who is assistant superintendent of the Vancouver branch of the Victorian Order of Nurses, won second prize in the 1946 essay contest sponsored by the *Journal*.

Eleanor R. Wheler is public health nurse in Summerside, P.E.I. Who would not like a job on "The Island" after reading this progressive account? Lois Lethbridge is superintendent of the hospital in Portage la Prairie, Man.

Mabel G. Lawson was asked to assist with the re-organization of nursing in Germany. Miss Lawson, who is unique in that she received her doctor's degree before she entered as a student in St. Thomas's School of Nursing, is presently deputy nursing officer with the British Ministry of Health.





Better physical management

OF MENSTRUAL HYGIENE

TAMPAX, functionally correct internal menstrual guard, eliminates the physical objections to (and discomforts of) the older type of protective device... because... its unique functional design assures comfort in use—affords adequate protection—and precludes disintegration in situ; ... its small cross section renders

insertion and removal so
easy—and carrying and
disposal no problem at all;
and . . . its intravaginal
application eliminates odor,
chafing and perineal irritation
—permitting fuller enjoyment
of sports and social functions
without discomfort from belts,
pins, and bulky pads . . .

Available in three absorbencies:
Regular, Super and Junior to
fit individual requirements. The
coupon below is for your convenience.

TAMPAX

FOR BETTER PROTECTIVE MANAGEMENT
Accepted for Advertising by the Journal of the American Medical Association

Canadian Tampax Corporation Ltd. Brampton, Ontario.

Phase send me a professional apply of the three above better of Tampay together with Stendaric Including a summary of 6800 cases.

Name
| Televast Exist
| Address | City | Prince | Prince

"for the prevention of rickets...

for good bone and tooth development
... and for excellent growth"

400-UNIT CARNATION MILK

... is accepted by the Council on Foods and Nutrition of the American Medical Association as being effective in accomplishing the purposes indicated above, with normal infants and with children between infancy and adolescence.

Carnation Evaporated Milk provides 400 Int. units of vita-

min D per reconverted quart (half Carnation, half water). It is vitamin D increased through irradiation with ultra-violet light.

Careful plant and laboratory controls and regular bio-assays give assurance that the vitamin D potency of Carnation Milk is always maintained at this approved and beneficial level.

CARNATION COMPANY, LIMITED, TORONTO





That April shower won't bring you flowers!

Your shower or bath is great for washing away past perspiration, but Mum protects underarms against risk of odors to come. So to win bouquets use Mum after every bath or shower to guard your charm.

Mum

better because it's Safe

- 1. Safe for skin. No irritating crystals. Snow-white Mum is gentle, harmless to skin.
- 2. Safe for clothes. No harsh ingredients in Mum to rot or discolor fine fabrics.
- 3. Safe for charm. Mum gives sure protection against underarm odor all day or evening.

For Sanitary Napkins. — Mum is gentle, safe, dependable . . . ideal for this use, too.

Special to Public Health
Nurses: Mum's Personal Grooming
programme now
includes "Grooming For School"
charts and leaflets.

Write for your copy.

Product of Bristol-Myers Company of Canada Ltd.
3035 St. Antoine Street, Montreal 30, Que.

FINGER ON THE PULSE:

Tut, tut, Ferdinand: Letting her pet bull loose cost Mrs. Isobel Ogilvy of Malling, England \$17.50. Said the judge: "A serious offence that this coarse type of animal should be allowed to run loose among good cows with a possibility of breeding".

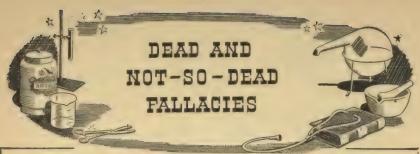
Legitimate squawk: A villager of Agra, India, had a complaint concerning a purchase he made on the black market. He told the police that the \$1,500 bride he bought turned out to be a boy.

Any arguments? Gerald Clark of Chicago has a cure for the worn-out world. He suggests that everybody take a week off for sleep to cure a lot of mankind's problems. Mr. Clark's occupation? — bedmaker.

Due for a stretch: Police were hunting for a thief in Woodstock, Ontario, who snatched girdles from clotheslines.



"Miss Jones, I find myself run down, irritable, grouchy. AM I?"





Many newborn babies, 300 years ago, were tightly wrapped in swaddling bandages so that they could not move.

This treatment was believed to shape the bones properly. Every other one of the babies so treated died during the first year.



Many mothers believe that canned foods that have become frozen are not good to eat. This is far from the truth.

Although some foods may change in appearance by freezing, the health values are not affected,



A M E R I C A N C A N C O M P A N Y
MONTREAL HAMILTON TORONTO VANCOUVER

City

N	ow	av	aila	ble	on	requ	est-
82	TH	E	CA	NN	ED	FO	OD
R	EFE	ER	ENC	E I	AN	NU	AL"

—a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

CANNED FOOD IS GRAND FOOD

AMERICAN CAN COMPANY	
Medical Arts Building, Hamilton, Or	nt.
Please send me the new Canadi edition of "THE CANNED FOO	
REFERENCE MANUAL," which	is
free.	
Name	
Professional Title	
Address	

Province.



Johnson's DRAX means less laundering . . . easier laundering!

Here is a completely new and different laundering aid . . . Johnson's DRAX. Not a starch, not a soap, DRAX is an invisible wax rinse that protects fabrics from dirt, soil and water! They stay clean and fresh-looking longer . . . and they're easier to wash!

DRAX... made by the makers of Johnson's Wax... may be applied to any washable fabric: uniforms, curtains, tablecloths, bedspreads. It is easy and inexpensive to use. You need no special equipment or special skilled help. Yet it cuts down on washing time, on washing frequency, on washing costs!

Any institution or concern that uses large quantities of washable fabrics in their equipment will find that it pays to use DRAX. Why not find out about DRAX today!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

APRII , 1947

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to: Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. O.

V.

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

-- One-Year Certificate Courses-

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing, Public Health Nursing. Administration and Supervision in Public Health Nursing.

> For information apply to: School for Graduate Nurses

> > 1266 Pine Ave. W.

McGILL UNIVERSITY, MONTREAL 25

UNIVERSITY OF MANITOBA

Post-Graduate Courses for Nurses

The following one-year certificate courses are offered in:

- 1. PUBLIC HEALTH NURSING
- 2. TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
- 3. ADMINISTRATION IN SCHOOLS OF NURSING

For information apply to:

Director

School of Nursing Education University of Manitoba Winnipeg, Man.





CONESTRUN

NATURAL CONJUGATED ESTROGENS

(equine)

ORAL THERAPY WITH CONESTRON provides safe, dependable control of menopausal symptoms and restores the patient's sense of well-being.

ORAL THERAPY WITH CONESTRON is relatively free from undesirable side effects.

ORAL THERAPY WITH CONESTRON is most desirable from the standpoint of convenience and time economy.

CONESTRON TABLETS

May be prescribed in any quantity. Available at all pharmacies in two strengths.

.625 mg.



1.25 mg.

Registered Trade Mark

JOHN WYETH & BROTHER (CANADA) LIMITED . WALKERVILLE, ONTARIO

APRH., 1947



sugar tablets look and taste like candy, but they also come in the convenient dosage size, 0.32 Gm. (5 grs.). Wholly palatable, they may be chewed, dissolved slowly on the tongue or crushed and given in half a teaspoonful of water. Sulfadiazine Dulcet Tablets are available at all pharmacies in bottles of 100. A circular giving full directions and contra indications will be sent on request.

ABBOTT LABORATORIES LIMITED, Montreal, 9.

Sulfadiazine Dulcet Tablets

(2-Sulfanilamidopyrimidine)

ABBOTT



The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER FOUR

MONTREAL, APRIL, 1947

encencence continue to the content con

Manitoba's Watchtower

FROM where we stand we can look backward and survey the landscape behind us, representing our accomplishments, and we can look forward to the horizon representing our hopes for the future. What do we see? Far behind us we see the establishment of qualifying examinations for the first-year student nurses. Following their establishment we found two hurdles in our path that had to be crossed before these examinations became reasonably smoothrunning:

- 1. Problems that arose in connection with candidates who were unsuccessful.
- 2. The length of time a student can spend in a training school before she is eventually disqualified should she be unsuccessful.

Dealing with the first problem, we found, as one might expect, that a number of unsuccessful students appealed to the Board of Directors for special consideration or special privileges. Had such privileges been granted to one, it would have immediately raised a storm of protest

from others less favored and so our only possible course was to point to the standards that had been accepted. even though in some instances our sympathies might be with the student. This problem was solved when the University of Manitoba Liaison Committee kindly consented to act as an Appeal Board for students who are eliminated in either qualifying or



BERYL STEMAN

registration examinations. (We are fortunate in that all M.A.R.N. examinations are conducted by the University of Manitoba, with which we have a Liaison Committee. This committee is composed of representatives from the university, the M.A.R.N., doctors, and the Manitoba Hospital Council.) The Appeal Board has the right to grant permission to any candidate to write the examinations again if they feel that extenuating circumstances have contributed to her failure. It is understood that no decision forms a precedent that must be followed subsequently in similar cases. Each case stands on its individual merits. The Appeal Board has both granted and refused a number of appeals since its inception.

In considering the second problem, we had to bear in mind the length of time it would take to cover the essential material before a student would write, and the length of time we felt it was justifiable to keep her in a school of nursing in the event that she should be unsuccessful. Students now write their qualifying examinations about nine months after entering the school. A set of supplemental examinations is offered three months after this time. By this means, students are either eligible or disqualified within a year or a little more after entering the school. (Actually it is necessary to set only one set of supplemental examinations, since students failing in June write the regular September examinations as their supplementals.)

We have taken yet another step towards standardizing student learning in Manitoba nursing schools. It has been decided to hold Instructors' Worskshops annually. At these workshops, course outlines are being formulated and when this has been fully accomplished they will be subject to annual revision. These outlines have been mimeographed and distributed to each school of nursing and each instructor in Manitoba. Each tested subject eventually will have been so considered. The outline includes a

suggested minimum number of hours for each subject. Such outlines should do much to promote greater uniformity in standards of teaching and testing throughout the province.

We are grateful for the wisdom of some of our early members whose far-sighted action is bearing fruit for us today. Life insurance, in the form of endowment policies, was placed on four of our members, naming the M.A.R.N. as beneficiary. When these policies matured, the money was re-invested and the interest is to be used to award a M.A.R.N. scholarship for post-graduate study annually.

Just before Christmas, 1946, some of us were privileged to attend the graduation exercises of the first class of practical nurses trained under the government-sponsored Practical Nurse Act. Before this time many practical nurses, who had attained acceptable standards of training and experience, had been granted the license issued by the Department of Health. We now have a sizable group of licensed practical nurses ready to make their contribution to the community. Their duties and limitations have been carefully outlined and they are now employed in private homes and all types of hospitals with the possibility that their services may be utilized still farther afield.

When this Act came into effect, it brought with it a problem — different, in that it was a welcome problem. The Act makes it illegal for anyone to practise nursing for remuneration in Manitoba who is not either a registered nurse or a licensed practical nurse. There is a group of nurses in the province who have been practising without registration. Many of these nurses have been rendering splendid service and, in many instances, it may have been the result of unwise counsel that they failed to procure registration at the time of their graduation. The problem is that these nurses can no longer practise without registration. would be placing them under a serious handicap to ask them to write presentday registration examinations that are based on a curriculum very different from that in effect at the time of their graduation. A solution has been reached by asking the University of Manitoba to conduct a special examination for this group, based on general nursing knowledge. It is expected that this examination will be offered only once so, before it takes place, wide publicity will be given to the place, time, and necessary qualifications of candidates. Any of these nurses who do not present themselves for this examination, or who fail to qualify for registration through it, will still be eligible to become licensed practical nurses.

The Manitoba Health Plan familiar to everyone and such undertakings of a community-wide nature are always of vital concern to nurses. The Manitoba Hospital Council, with a view to lending a guiding hand, has been formulating an outline of standards for public hospitals. request of the council, a committee of the M.A.R.N. has undertaken to outline, in their different aspects, standards of nursing for these hos-In another avenue of community endeavour, two of our members represent us on a committee set up by the Minister of Health at the request of the Advisory Commission under the Health Services Act. This committee is studying the current nurse shortage and possible means of overcoming it.

The need for the interpretation of nursing to lay people is a frequent point of discussion in nursing circles and this need forms the nucleus of one of our cherished hopes. At our forthcoming annual meeting, which is planned for April 21 and 22, a plan for an Advisory Committee to the Board of Managers will be placed before the general membership for their consideration. The committee, as outlined at present, would be composed of both men and women and would represent a broad cross-section

of community thought. We feel that through this committee, our aims, hopes, needs, and problems could be interpreted much more widely than would otherwise be possible, and the advice and detached viewpoint that they could bring to our discussions would be exceedingly valuable. Such a group would be most helpful to us and, ultimately, to the community.

There are clouds, too, in Manitoba skies. One that is now almost directly above us makes us very unhappy. There has been no permanent source of finance forthcoming to support the School of Nursing Education within the university. Great was the rejoicing when the school first opened its doors in 1943, supported by the Federal Grant. The Department of Health, following our representation to it, very generously provided financial support for two years following withdrawal of the Federal This is a province with an admirable and rapidly-expanding health program. It is to be regretted that the facilities to prepare fullyqualified nurses to make a worthwhile contribution to it are jeopardized. The continuing need for the nurses who might graduate from the school is frequently expressed by people who utilize their services, but it appears that in spite of all our efforts this hard-won prize will be lost to us unless some unforeseen good fortune supervenes.

This, then, is the scene that can be surveyed from Manitoba's Watchtower. The constant endeavour of the people within the watchtower is to maintain an awareness of the everchanging needs of the community, the profession, and nurses themselves. It is only through such awareness of changing needs that our efforts can attain their greatest usefulness.

BERYL SEEMAN
President
Manitoba Association
of Registered Nurses

No great ability is required to disorganize a group, but to hold people together for a constructive purpose is a challenge to the intellect.—Charburough, 20 B.C.

Eye Care

CHARLES A. THOMPSON, B.A., M.D., C.M.

DISCUSSION of the care and the A prevention of injury to the eyes deserves to start with a brief review of the anatomy of the eve. lids are lined on their inner surfaces by the conjunctiva which passes on to the eye as the bulbar conjunctiva and forms the superior and inferior cul-de-sac. The optic nerve pierces the sclera near the posterior pole of the eye and spreads out inside as the retina. This is the seeing layer. Beneath this is the vascular area, the choroid, which runs anteriorly as the ciliary body and iris. there is the outside layer, the sclera, which gives the eye its shape and runs anteriorly to become transparent and forms the cornea. junction of the cornea and the sclera is called the limbus and is always used for defining positions of the various normal structures, foreign bodies, etc. From the cornea pos-

Adhesive
Applicators
Bandages (½ inch gauze)
Binocular loupe
Condensing lens
Knapp's patches
Sterile cotton
Sterile eye droppers

What is expected of the industrial nurse? She should limit her treatment to acute conjunctivitis, the removal of superficial foreign bodies, the visual acuity tests, the treatment of superficial abrasions, and instruction in hygiene and preventive measures.

Eye Injuries

Foreign bodies: The superficial eye injuries result from foreign bodies striking the cornea. The dictum, "The deeper the foreign body the more permanent the scar," is emphatically true. To remove a superficial foreign body, wrap sterile cotton

teriorly, we pass through the anterior chamber (that is, the space between the lens, cornea, and the iris) and the lens, and then to the chamber enclosing the vitreous humor. The ciliary body lies a quarter of an inch behind the limbus. called the danger zone of the eye and from here the ciliary process is attached to the lens by the Zonule of Zinn. Returning to the lids, there is a small elevation near the inner part called the punctum lacrimale and from this point the tears begin their passage medially, then into the lacrimal sac and down into the nose. Remember this, as it is often overlooked in injury to the lids.

Before outlining the treatment and diagnosis of conditions the industrial nurse may meet, let us review what she needs by way of equipment and supplies in order to care for eye in-

juries:

Argyrol 25%
Atropine 1%
Boric acid sol. and irrigator
Castor oil
Fluorescein 2%
Pontocaine solution ½%

Some antiseptic ointment, such as sulfathiazole or white precipitate of mercury.

about the tip of an applicator and soak it in boric acid. After having instilled a drop of pontocaine ½% into the eye, wipe gently over the foreign body and remove it if possible. Don't scrape back and forth. If the foreign body is imbedded and cannot be dislodged with this treatment, send the patient to an ophthalmologist after covering the eye with a Knapp dressing. Give a short history of the time of injury, the possible material of the foreign body, and the treatment that has been carried out.

If the foreign body is not visible on the cornea, see if it is under the lid. To evert the lid, place the patient in a good light and ask him

to look down. Stand behind him, tilting his head back against you, then grasp the eyelashes with the thumb and index finger of the left hand and pull the eyelid forward and downwards. Lay the rim of a coin or an applicator along the upper margin of the tarsal cartilage and

turn the eyelid upwards.

The foreign body still may not be visible, so stain the cornea with 2% fluorescein by applying a drop in the conjunctival sac. Wait for several minutes and then irrigate the fluorescein away. An abrasion of the cornea will show up as a bright green spot. If an abrasion is present, the reflection on the cornea of the foreign body will appear as a broken line. After the foreign body is removed or if an abrasion is seen, place some sterile ointment, such as boric acid, between the lids and cover with a patch. Be sure to see the patient the next day. Test his vision when the eye is healed just as you did when he was first examined.

If an injury occurs at the inner margins of the lids there is a grave risk that the tear passages will be damaged. Unless the condition is recognized at once and a path for the escape of the tears opened up, complete obstruction will take place in the process of cicatrization, and the patient will suffer from persistent watering of the eyes. These conditions appear obvious but are often neglected.

Burns: Of all injuries to the conjunctiva none is more disastrous in its results than a burn, especially one due to the action of chemical irritants such as quicklime or sulphuric acid. Prognosis must be guarded, for what looks like a very small lesion in two weeks may have spread over the cornea and result in

the loss of vision.

In all severe burns, both bulbar and palpebral conjunctiva are destroyed, and the raw surfaces that are left adhere in the process of healing so that the eyelid becomes firmly fixed to the eyeball. Burns of the conjunctiva and cornea due to alkali or acid should be treated by

prompt flushing of the conjunctival sac with water, using considerable force. Pick out any loose pieces of foreign body and instil castor oil immediately.

If the burn is superficial ice compresses applied for fifteen minutes over the lids will relieve the pain and photophobia. Where the burns are deep, hot compresses are indicated to increase the vascularity so that the cornea will get sufficient nourishment. However, do not treat these patients yourself. Send them to the

ophthalmologist.

Electric ophthalmia: This is occasionally observed in those engaged in electric welding operations and usually appears about eight hours after the eye has been exposed to the glare, the evil effects of which are due to the predominance of ultra-violet rays. The eye feels hot and prickling and there is swelling of the skin of the lids and face similar to that which is seen in severe sunburn. The tears gush from the eyes in large quantities. The symptoms gradually subside in one to two days and much relief is obtained with pontocaine 1/2% and ice compresses. Preventive measures are very important.

Contusion of the eye: A black eye is the simplest. The swelling and discoloration may be kept in check by application of cold, and a pressure bandage when the injury is more severe. Emphysema of the lids should referred immediately to an ophthalmologist or otolaryngologist as it may indicate a fractured frontal or ethmoid sinus. Here a pressure bandage is indicated, as first aid treatment, with instructions to the patient to refrain from blowing his nose. The nature of this soft swelling is distinguished by its crackling to touch and the ability to increase its size by blowing the nose. Injuries about the frontal or malar regions sometimes cause blindness due to fracture through the optic foramen. A fracture of the sphenoidal fissure may cause an ophthalmoplegia externa and interna.

When the eyeball is itself damaged it is well not to trust to a purely ex-

pectant line of treatment but send the patient to an ophthalmologist with a bandage over the injured eye. Blows of some severity are complicated by hemorrhage, whether subconjunctival or intraocular. In subconjunctival hemorrhage the effused blood forms a clot visible through transparent conjunctiva and bounded in front by the corneal limbus. The blood disappears in several days to several weeks. If the hemorrhage occurs several days after the injury, the patient may have a fracture through the anterior fossa of the skull. Intraocular hemorrhage is always dangerous but it is much more serious when in the vitreous rather than the aqueous humor. Sometimes the iris is separated from the ciliary attachment causing an iridodialysis.

There are many other complications but as they will show the eye to be seriously injured you will pass them on to your doctor as quickly as possible. Always remember that a blow to the eye may cause injury deep in the eye that may only be seen with the ophthalmoscope. If the patient complains of defective vision in any field be sure he is seen by a doctor immediately as detachment of the retina or a dislocated lens may be

the cause of the complaint.

Penetrating wounds may be caused by the smallest of foreign bodies and may not be felt. Hot metal, for instance, will anesthetize the globe and give less discomfort than a superficial foreign body on the cornea. Penetrating wounds may carry with them infection. Aseptic wounds are to be found only after carefully performed operations. The difficulty in diagnosing these seemingly trivial cases will be considerably lessened if care be taken to examine the tension of the globe as the intraocular tension is diminished in these

Any perforating wound through the ciliary region carries with it the possibility of sympathetic ophthalmia. This condition has been

cases. Nurses should familiarize

themselves by feeling the normal

tension of the eye.

known to come on as soon as four days after the injury but usually does not appear for two weeks and may not make its presence known for years. In this condition an inflammatory lesion develops in the uninjured eye, the cause of which is unknown.

If a small tear in the lid or conjunctiva has been observed draw it to the attention of the doctor as it may be the portal of entrance of a foreign body and may not be noticeable by the time the doctor sees your patient.

PREVENTIVE MEASURES

Any program of prevention starts with proper hygiene of the eyes and suitable instructions regarding the seriousness of the slightest injury to the eye. All men or women on entering employment in a factory shop should have: (1) Their visual acuity accurately determined. (2) The lids, cornea, and anterior segment examined for any obvious diseases or defects. (3) The field of vision studied, using the confrontation test. For this test, the patient is seated with his back to the light, two feet in front of the examiner. The patient covers one eve and with his other eye stares at the examiner's eye in front of him. The examiner covers the opposite eye, that is, the patient's right eye is covered and the examiner's left eye. The hand, with fingers extended, is moved from the periphery inward midway between the patient and the examiner. The fingers should be seen simultaneously by both persons if the fields of vision are normal. (4) Instruction in the proper care of the eyes at his work should be given early to each employee. There should be good lighting so that the worker can clearly see what he is doing without any strain to his eyes. If he is a welder he must wear his glasses; if a grinder, he is likewise taught to protect his eyes with proper shatter-proof glass or shield.

Since the employees in any plant may include a wide range of age groups, and since presbyopia, the impairment in vision due to advancing years, alters the vision for near and distance, frequent examination of the acuity of vision is necessary. Also remember that when one eye is occluded, depth perception is lost and the patient's ability to judge distance is greatly impaired.

It would be an excellent idea to have bottles of pontocaine ½% and of normal saline in any area where men are working with lime or acids as the end result depends on the speed with which the material is removed from the eyes and treatment is begun. Always remember to put in castor oil or a substituted oil following a burn.

FLUORESCENT LIGHTING

The Committee on Industrial Ophthalmology has made a report concerning the effects of fluorescent lighting on vision. Since this type of lighting is being used much more frequently, it will be useful to nurses to have this information:

- 1. Light from fluorescent lamps resembles daylight more closely than that from tungsten-filament lamps.
- Ultra-violet energy from clear, blue sky is four times as great per foot candle as fluorescent light.
- 3. Fluorescent light generates less heat per candle power than tungsten lamps.
- Glare occurs in any system of lighting.
 Its solution rests with illuminating engineers.
- 5. Twenty-foot candles are essential for reading and higher levels of illumination are desirable for prolonged seeing.
- Excessive light may produce symptoms of eye-strain in susceptible individuals regardless of source.
- 7. Noticeable flicker is largely eliminated in modern fluorescent installation.

Summary: Fluorescent light is not harmful to vision. It should not cause eye-strain if properly installed.

ACUTE DISEASES OF THE EYE

Styes or chalazions: The treatment should start with hot water compresses every three hours. Argyrol 25% should be instilled followed five minutes later by irrigation. This should be done every three hours. Be sure

the argyrol is fresh at all times.

Acute simple conjunctivitis or pink eye: Here the palpebral conjunctiva is infected and edematous. The emergency treatment is argyrol 25% instillations with irrigations five minutes later, adequate care being taken as this condition is contagious. Remember, do not apply a patch in conjunctivitis.

Corneal ulcers: Stain the affected eye with fluorescein. If an ulcer is suspected, the patient should be sent immediately to the doctor for treatment as this is a potentially dangerous

eve condition.

Iritis: Here there is ciliary infection about the limbus with an iris which reacts poorly to light and is tender over the ciliary zone. The pupil is also small and the eye painful and sensitive to light. As the treatment is difficult and long, refer the patient to the doctor. In the event of unforeseen delay, if an iritis is suspected, instil atropine 1% in the eye as the sooner it is dilated the better the prognosis.

Conclusion

If you want the eyelid closed, as in the presence of a superficial foreign body, place a pledget of cotton on the upper lid just below the brow and then apply the patch. This, as you can see by using your finger as a pledget, will keep the eye closed. When fastening the patch in place, do not put the medial strip of adhesive near the corner of the mouth. The patient will not be able to open his mouth without discomfort and if he does open it he is likely to tear the adhesive away from the skin.

To apply hot water compresses, get a wooden spoon, fill it with cotton, cover this with a gauze bandage, and tie it securely around the spoon handle. The patient can then apply his hot water compresses for himself without burning his fingers or contaminating the compress.

To place drops into the eye, have the patient look up, pull the lower lid down, and set the drop on the conjunctiva, not over the cornea. Do not touch the lid with the dropper.

Nutrition Education and the Public Health Nurse

H. RUTH CRAWFORD

Unquestionably, the practice of good nutrition would be futile in a society where all other aspects of healthful living were unobserved. On the other hand, no public health program is completely adequate without the inclusion of many factors related to nutrition.

The fact that the nutritional status of most people in Canada today is probably at a higher level than ever before is not cause for an attitude of apathetic indifference towards nutrition. There are still many families whose food habits are far from desirable and who stand to benefit from some form of practical, effective nutrition education. Poverty is seldom the sole cause of poor nutrition. It is frequently ignorance or disregard of food values and the relation of food to health that is the chief problem. Because a family has a sufficient amount of money to buy an adequate diet does not assure that they will obtain it unless they know what an adequate diet is.

What, then, are the most effective ways of disseminating information about nutrition to these families? There are obviously three major channels through which one may attempt nutrition education: (1) The mothers in the homes; (2) the children in school; (3) community organizations.

With respect to group 1, the mothers, one is aware of the numerous agencies, commercial and otherwise, already distributing large numbers of calendars, pamphlets, and posters on nutrition to them. In addition, cooking schools of the air may be heard at almost any hour of the day, and nutrition has become a frequent subject of speakers at women's meetings. Unfortunately, those who actually benefit most from such numerous and costly educational procedures are almost invariably the ones

who are least in need of them. It is the alert, intelligent woman who avails herself most often of the educational opportunities presented to her, while the one who lacks interest in nutrition, and is consequently careless about her family's eating habits, remains unaffected. Experience has shown that by far the most effective means of arousing the interest of such a person in good food habits is through personal contact in the home. Few communities are large enough, or have sufficient finances, to have a nutritionist on the public health staff. The responsibility for nutrition education in the home, therefore, rests with the public health nurse, who, better than anyone else, is aware of the homes most needing advice, and is able to gain entrance freely to them. A few simple, practical suggestions made to the mother concerning a particular problem encountered in feeding her family is of much greater value than volumes of confusing literature left at the home.

Thus the visiting nurse must have appreciation of many factors related to nutrition if she is to meet the highest standards of community care. It is imperative that she be capable of instructing pregnant and lactating mothers in the need for an adequate diet to protect their health, to furnish the materials needed for the baby's growth and development, and to maintain lactation. Then, by stressing the need for developing good food habits in the infant as he begins to eat solid foods, the nurse may stimulate a greater interest in nutrition for the whole family, since their attention is, of course, focussed on the well-being of the young child. The first five years of life are the years during which a child acquires basic, lasting habits. The public health nurse should,

therefore, make certain that mothers of preschool children in her district are well aware of the foods which their children should have, and of the need for developing as wide a range of food likes as possible. In addition to securing an adequate diet, these children should receive a special source of vitamin D daily, and it should be stressed that they not be given sweet foods, such as cake, soft drinks, and candy.

In many homes, knowing what to feed the child may be less of a problem than getting the child to eat what is served him. In such cases, only a few helpful ideas may be needed to overcome the difficulty. For instance, a child may refuse to take cod liver oil when it is thrust at him by an over-anxious mother, whereas if he is allowed to pour it for himself, it becomes a new responsibility for him, which he takes pride in performing. The introduction of new foods, as of disliked foods, frequently causes an undesirable scene. Mothers should be cautioned to give such foods in very small amounts, and along with foods that are very well liked. At the same time, the adult attitude should be one of unconcern, of simply expecting the child to eat, rather then coaxing and bullying him into The child then realizes that his refusal to eat is not getting him any attention and, since his main incentive for not eating is gone, he settles down to enjoy his meal. By assisting parents in this way to develop in their children proper attitudes towards food and habits of eating which contribute to normal growth and development, the public health nurse can do much to eliminate malnutrition and impaired health.

Some mothers may wish to have guidance in food purchasing and menu-planning. Naturally, a plan that suits one family may be quite inappropriate for another. Such things as the family's size, existing dietary habits, social customs, and economic status must all be taken into consideration. The

amount of kitchen equipment available will likewise have an effect on the nature of the meals that are prepared. For example, a family with a coal stove burning all day will be able to prepare cheaply dishes such as beans and stews, which require long slow cooking. A family with a gas-range might find these foods uneconomical because of the large amount of fuel required. There is a great deal of illustrative material, available on request from government agencies, which may be of assistance in this connection, provided the nurse interprets the material to the individuals, pointing out the application to their problems.

To have a better understanding of food economics and the relative monetary and nutritive value of the food dollar, the nurse should go to the stores or market in her district. and actually price foods, looking for quality in them and learning in what units food may be purchased most economically. In this way, she acquires a practical knowledge of the situation that she could gain in no other way. For instance, she discovers that bulk goods can be purchased much more cheaply than packaged, that topless carrots are only half the price of imported ones with tops, that minced shoulder of beef gives twice as much for the money as minced round steak, yet is just as good for meat loaf or pie. By careful inspection of the various packaged cereals for sale, she learns to recognize which are the very nutritious whole-grain variety, and which are the expensive, highly refined type, lacking in essential nu-The aim is not to make nutritionists out of public health nurses, but rather to equip them with the right kind of information so that when they enter homes where children are living on diets of cake and coffee, they are in a position to give much needed help and suggestions, and are able to interpret the facts to suit the family's particular requirements.

The public health nurse is always in very close contact with children in schools. Here, there is every

opportunity to carry on an effective program of nutrition education as an intrinsic part of the general health program. No school curriculum in health is complete unless it includes this subject, and the nurse should be able to give the teachers much assistance in preparing their lessons. The aim of the nutrition teaching should be to provide the children with sufficient knowledge of the foods essential for healthful living that they may be able to select food intelligently and permanently establish good food As mentioned previously, nutrition education is especially important for the very young children, since their food habits can be influenced with much less difficulty than those of older children, who have become quite fixed in their ways. However, children of all ages need this phase of education while at school, for there is little assurance that the great majority of them will ever receive adequate nutrition education elsewhere. This learning holds much of immediate value for all pupils and is of potential value for the citizen of the future. At the same time, this information which the children carry home from school is almost certain to be transmitted by them to their parents, who might not have been reached in any other way.

If nutrition teaching is to be most effective each teacher should be made aware of the major defects in dietary habits prevalent among the children. The public health nurse can aid materially in this way, by pointing out what food habits she has found need changing, and what teaching methods will produce the best results in terms of improved health. For example, she may have observed that many of the children are refusing to eat vegetables at home. She may then advise the teacher of this and suggest that the pupils be asked to bring to school one kind of vegetable each. These may then be studied in class and perhaps made the object of a "tasting party." In this way the strangeness of the various vegetables disappears and the children develop an active interest in them. Similarly, the nurse may have found the consumption of milk by the children inadequate. By informing the teacher of the situation, some class activity which would stimulate an appreciation of milk, such as a poster competition, might be organized.

The school lunch program is an excellent practical application of nutrition teaching and, if wellplanned, serves two important functions. It not only directly improves the nutrition of many of the children, but also has definite educational values which should be understood and utilized to the fullest extent. Many schools neither need nor have a complete lunch program but, where one is in operation, the nurse should give attention to the nutritive value of the meals served, the eating habits of the children, and the sanitation of the lunchroom. The meals should provide generous amounts of the protective foods, whole-wheat bread rather than white, no cake or pastry, and should include as wide a variety as possible of vegetables. Candy and soft drinks should not be for sale in the school lunchroom. They both diminish the child's appetite for more essential foods, and develop a greater taste for sweet foods, thus promoting tooth decay. It is chiefly rural children who must stay at school for lunch. If it is impossible or impractical to provide them with a complete noon lunch, the interest of the parent-teacher association might be aroused in providing at least one hot dish for the children to eat along with the lunch brought from home. The necessary equipment costs very little and the results will be well worth the small amount of effort involved in prepara-Occasionally it is necessary to provide some children with special supplements daily. The public health nurse may find supplements such as cod liver oil or milk, advisable in certain districts where they are unobtainable either from economic causes or unavailability; when this is the case, it should be drawn to the attention of the proper authorities.

The third channel through which the public health nurse can work to improve the standard of nutrition includes community organizations and agencies interested in health activities. She can effectively guide them in their projects and make suggestions for their programs, based on local needs. If obvious nutritional defects are present she can enlist the cooperation of community groups in overcoming them, and stimulate their interest in developing necessary facilities and services for the early recognition and correction of physical defects which may interfere with normal nutrition, such as decayed teeth, diseased tonsils, and faulty posture.

Prenatal and well-baby clinics play such an important role in the general health program, that they are flourishing in almost every community. It is especially advisable that the public health nurse or the doctor provide expectant mothers and mothers of young babies with such nutritional information as they may need to ensure their optimal nutrition.

At these clinics, and at special nutrition meetings or club programs into which some aspect of nutrition education is introduced, it may be worthwhile to distribute printed pamphlets or illustrative material. These are of most value when they are directed toward a definite end and serve to emphasize a specific point that is being made. Films and slides may also be used effectively at group meetings to develop interest and clarify thinking with regard to a certain situation. The public health nurse should be aware of all available sources of educational materials in nutrition and make use of them to best advantage.

Again, it should be pointed out that nutrition is only one factor affecting health and, therefore, should not be emphasized in the general health program to the exclusion of other related factors. However. nutrition education can be developed in conjunction with other phases of health education in such a way that the balance of all the factors that make for healthful living becomes apparent and significant. The public health nurse has a continuing privilege as well as a responsibility in being able to play a large part in bringing this knowledge of health and happiness to everyone in her community.

Salt as Sausage Preservative

Tests conducted over a period of nine months have disclosed that fresh frozen pork sausage prepared without salt keeps better than the same product prepared with salt. These tests were made to determine a satisfactory method of preparing sausage for freezing to provide maximum stability, appearance, and palatability. It had been found that fresh frozen pork sausage developed rancidity after relatively short periods of storage at temperatures of 0 and 15°F.

Three lots of sausage from the same initial stock were identically prepared except for seasoning ingredients. One lot was seasoned with sage, pepper, sugar, and salt. Another contained sage, pepper, and sugar only, and the third contained no seasoning. Samples were prepared from all lots, frozen at zero degrees, placed in storage at that temperature,

and every thirty days portions were removed from each lot and submitted to chemical as well as taste tests.

At the end of three months it was noted that the sausage which contained salt had deteriorated in appearance, flavor, and odor. After each succeeding month of storage and subsequent examinations, the samples containing salt continued to deteriorate in all respects. The tests indicated that seasonings other than salt had but little effect on the development of rancidity in the sausage during freezing, storage, and cooking. On the contrary, the type to which sugar, sage, and pepper had been added were slightly more acceptable and had lower deterioration values than the type to which no seasoning had been added.

-News Notes No. 55

Learning Activities

The Late KATHLEEN M. STANTON

EVERY course which is included in the curriculum for the education of student nurses must have certain definite characteristics and effects if it is to prove worthwhile. Inherent in the subject matter of the course will be certain abilities which, by their effect on the student, will result in learning. Each course should affect: What the student thinks (an intellectual ability); what the student does (a motor ability); and what the student feels (an emotional ability). In the process of interpreting the material in each course to and with the students, the teacher has the opportunity to turn all of these responses into the desired channels. The end result of this change will be the product. Thus the products of thinking are: understandings, ideas, concepts, knowledge; the products of doing result in the development of habits, skills, the ability to do things; the products of feeling lead to the formation of attitudes and ideas, an appreciation of the patient as being more than just a case but an interesting personality as well.

The teacher must plan, organize, and control the learning situation in such a way that the student's response will be satisfactory in all these abilities. The teacher must learn to estimate the effect upon the pupils. She knows from the beginning the effect, the product she wants to develop, and she should be aware of the activities that will achieve the desired end. It is important to remember that the student, too, has an aim. It may or may not be the same as the teacher's. Before effective learning can take place there must be a blending of these different goals. The teacher cannot take all of the responsibility for setting the goal but motivation

is all-important.

Learning is most economical of time and energy if it is methodical.

The various "methods" used in teaching should be evaluated in terms of certain criteria. When she has honestly searched her own mind and practices and has answered the following questions, the instructor will be able to judge if she is proceeding

in the right direction.

Why is she teaching? To be more specific, why does she teach student nurses? She is not only giving the students an insight into all the things to be learned about nursing, she is helping young women to develop as individuals. The majority of the class will be late teen-age girls, many of whom have never lived away from home before. Therefore, all of the needs of late adolescence must be met — cultural, social, and professional needs. These students must also be provided with a challenge the higher the intelligence of the group as a whole, the greater will be the challenge that they can meet.

This leads on naturally to the second question the instructor should ask herself: Whom is she teaching? With large groups of students there is a tendency to disregard the fact that each of them has individual interests, individual strivings, individual problems. Until she knows something of the background of each student, the instructor cannot draw the best from each. One of the most important steps in this recognition is that each instructor or supervisor who works with the students should quickly learn their names. There is something baffling and slightly ignominious for the young student when she loses her anonymity in a group.

The well-qualified teacher can answer the remaining questions quickly: What she is teaching; how she is teaching. She knows that only the most modern, scientific material should be given to the students. She knows that, in order to have this information readily available,

constant preparation on her own part is both essential and inevitable. There can be no such thing in nursing as the re-hashing of subject matter from year to year. Even in such a course as the history of nursing, contemporary developments must have a place.

How does she teach? The beginning of learning is *frustration* — our learning is being blocked. In our endeavour to overcome this blocking, we think, act, and do differently. Eventually, with mastery of the

problems, learning ensues.

The lecture method without student activity is being more and more discarded. In its place, the *socialized* methods are being used with planned active participation on the part of the students. Included in these methods are: individual conferences, group conferences, discussion groups, nursing clinics, demonstrations, nursing care studies, lectures, with plenty of student activity.

Discussion is a very fruitful method of learning if certain conditions are observed. The students are likely to be mentally alert and stimulated. The effort each makes to express herself clearly is in itself of great value. Ignorance and misapprehensions are quickly revealed and can be dealt with immediately. The chief difficulty with discussions is that the more self-assertive individuals are likely to talk too much, while shy students may never voluntarily say anything. There is a danger that irrelevant material will be introduced and side-track the main topic. It is important, therefore, that the problems to be discussed be carefully defined and delimited. At the same time, all aspects of the problems must be brought out and the students must be made aware of all of the implications involved. Participants must have had an opportunity to do some preparation; then, with the discussion focused on the problem, the group proceeds to look for the correct solution. Some sort of summarization must be given at the end of the discussion. Some form of activity grows out of the conclusions

which have been reached together.

Applied as a socialized method. the lecture becomes modified from the expert telling the group, a oneway process, to a sharing in which the teacher and pupils co-operate in the development of the ideas. A few important guides will assist the instructor to use this method more effectively. It is axiomatic that attention must be aroused. Never introduce any of the more important elements of the lesson in the first few moments - wait until attention has been accurately focused. Even in adults, the span of attention lags as the lecturer's voice goes on and on. Questioning becomes an important part of this method, therefore, to break the monotony of one voice and to permit of student participation. Stress should be laid on the questions which the learners ask of the teacher. Such questions are a natural manifestation of interest which the teacher should welcome heartily.

The use of textbooks, reference readings in current periodicals, summaries; etc., should be a recognized part of the students' experience of Illustrations, visual aids, the direct handling of equipment are all important aspects of study to which the student should be referred. Even a subject which is exceedingly interesting may have some dull or distasteful parts. Once the student realizes the vital connection of these parts to the important objectives which have been set, she will tackle them with the same energy. Study is drudgery only when it is unwillingly done because it seems valueless.

Nursing care studies are valuable means for the student to consolidate what she has learned. They often result in the emergence of new problems or subjects for study and thus are a constant stimulus. The following points should be given to the student to serve as guides in her study of an individual patient and the particular nursing problems associated with his illness:

1. What sort of a person is that patient?

- 2. How bad is his disease? (This should take in the interpretation of the laboratory findings but only as it relates to nursing care.)
- Purpose of the doctor's prescriptions. (This should include the therapeutic principles involved.)
- 4. Plan of nursing care—problems to meet. (The younger student deals with just the immediate problems. The more senior student deals with the immediate and long-term problems.)
- 5. What is the nurse's plan for teaching health principles to this patient?
- 6. What is her plan in getting this patient ready, e.g., for surgery? for any new treatment? to go home?

Encourage creative writing in the nursing care studies — not just the notation of facts according to a stereotyped plan.

The demonstration lesson aims, as its primary purpose, to develop the student nurse's ability to perform various skills efficiently. "We react as a whole to a whole situation." Therefore, an observation of the particular technique being carried out on the ward gives a vague concept of the completed procedure before it is demonstrated in the classroom. When the actual demonstration is given, the purpose of the procedure should be explained. A list of the necessary equipment should be given to the student prior to the demonstration so that she may anticipate each step in the preparation. The preparation of the patient to receive the treatment is stressed. In teaching the actual procedure, emphasize each step, the key points. These can be drilled upon later. The after-care first of the patient, then of the equipment — will round out the lesson. The summary should be given by the students.

Do not clutter up these demonstrations with too many explanations. The procedure being taught should be dramatized to make it appear lifelike—exactly as if it were being performed on the ward, with the conversation directed toward the patient. Since she has had the procedure-sheet given to her beforehand, the student knows what to look for.

Further explanations may be necessary following the demonstration. The student should practise the whole procedure then drill on the actual manipulation involved. She should be supervised for the total procedure on the ward, both to observe her mastery of the technique and to watch the timing.

One of the most important details of work the instructor in a school of nursing has to do is to plan for the most effective use of the physician's time as a teacher. Some guide to the purposes behind his lectures, and the points that it is desired he shall cover, will aid him in the preparation of his lessons. Taking as an illustration the medical lectures the physician will give, the following objectives might be outlined:

- To give the student a general understanding of the diseases and conditions requiring medical care and treatment with special emphasis upon the most common and most dangerous.
- 2. To give the student a thorough understanding of medical principles in order that she may be able to apply them in carrying out all the doctor's orders and efficiently reporting symptoms and effects of treatments.
- To give an appreciation of the patient as a member of a community who must be helped physically and mentally toward complete recovery.

Building on those objectives, a list of the points that he should cover would include the following:

- 1. To give a general knowledge of medical diseases (cause, pathology, complications, symptoms, treatment, and prognosis).
- 2. To give curative and preventive measures, pharmacology and therapeutics, in connection with each condition.
- 3. To give a thorough understanding of medical principles and practices in order that the nurse may carry out the doctor's orders efficiently and be able to report symptoms and effects of treatments intelligently.
- Subject matter included should serve as a rock foundation upon which to base their medical nursing classes.
- Patient should be studied as a member of a community and students should be interested in their means of recovery and rehabilitation.

6. An appreciation should be given of the great need for the application of mental hygiene, diet therapy, and health teaching in the care of medical patients.

7. To develop a personal responsibility for early recognition of medical conditions and the importance of early diagnosis.

8. To stress the most common and most dangerous medical conditions.

In conclusion, the accompanying graph, taken from page 19, *Technical Manual*, No. 21-250, Army Instruction, issued by the United States War Department, April 19, 1943, will illustrate how the complexities of the lesson-planning procedure can be simplified if thought and care is given to each step.

LESSON PREPARATION

Preliminary Planning

Determine	Formulate	Analyze	Determine	Determine	Plan methods
lesson	lesson	lesson	relation to	teaching aids,	of intro-
objective.	title. –	materials.	earlier lessons	equipment, and	ducing the
		Determine	and students'	materials	lesson to
		key points.	background.	needed.	students.

Presentation of New Materials

List	Select	Select	Plan	Prepare test
teaching	illustrations	methods of	application.	questions
points.	and •	presentation.		and problems.
	demonstrations			

Summary and Review

Prepare for summary	Prepare assignments
and	and
review of lesson.	references.

Allocate time to each part of lesson.

It's Not the Patient ... It's the Visitors!

Nona Blake as told to Louise Price Bell

Most patients are pretty reasonable—some of them are grand. It's the visitors which my patients have that get me down when I'm on a case!

Of course we all expect a certain amount of questioning and doubts from the immediate family if something we are doing for our patient seems painful or unpleasant. It doesn't make a bit of difference that you are following the doctor's directions out to the letter — they wonder if Dr. Smith "really meant you to do

it if it bothered Mary so much!" We all experience times like that, but it's the visitor I hold in awe — not a member of the family, just the casual friend or acquaintance, member of the patient's club, wife of her husband's boss . . . ad infinitum.

No visitor should stay long when visiting a patient, particularly a post-operative one. The smartest visitor I ever knew came every other day to see her friend after she had definitely understood from the doctor that visitors were welcome.

She always stood, even though I always urged her to be seated. After several days my patient asked her why she never sat down and made herself comfortable. "That's just why I don't sit down," the friend laughed. "I would be so comfortable that I would stay on and on and you would be all tired out when I left. Long ago I made it a practice to stand while calling on an ill person; when I begin to shift my weight from one foot to the other, I know it's time I left."

Wouldn't it be a godsend to our patients if we could post that sane rule on the foot of every bed?

So many visitors are inclined to forget that the patient may not like to be jostled the least bit; they no sooner get in the room than they perch upon the bed, or lean over with one arm pressing it, as they talk. To avoid this, I always try to offer a chair which is at a strategic spot where the visitor cannot touch the bed and where the patient will be able to see her caller without craning her neck or going to other uncomfortable extremes. Often I have switched the furniture about in hospital rooms while the patient was still in those first "bad days" so that when the time came to lift the "no visitor" ban and her friends started to flock thoughtlessly in, the chairs would be in the best positions for the callers.

Some people have naturally loud voices, and these invariably tire an ill person to whom soothing and quiet are important. With these people I have found that, if handled tactfully, they may be allied with you and feel rather important if you tell them that every little noise seems to bother "Mrs. So-and-So,"

and that you know that you can depend upon her to be as quiet as possible. If you add: "You might even mention this to her other friends," the loud-voiced person will not suspect that your entire efforts are really to keep her voice gentle.

Often food that is brought to a patient by well-meaning friends is not the type she can eat. A good nurse must handle that situation tactfully and can do so by graciously thanking the friend and carrying the food away to be properly stored. Often the subject never comes up again, whereas if you said: "Oh, I'm sorry, Mrs. Smith can't have any fruit!" the visitor would be crestfallen, and you wouldn't have accomplished a thing except to make her feel unhappy.

The longer I care for people as patients, the more I realize what a large part in their recovery and convalescence psychology plays. A mere mention of a subject in any way related to an unpleasant memory, or incident, will often start a patient off in a train of gloomy thoughts. If your patient is so ill that you have to stay in the room while her visitors are present, watch for any such conversational flaws and do your best to direct the discourse into other channels.

It it weren't for visitors, a nurse's job wouldn't be half so bad — at least that's the way it seems to me. If you agree, it wouldn't be a bad idea to leave your copy of this magazine within reach of one of your patients. She might learn something that would help her when she is well and takes on the role of visitor herself!

Streptomycin

Streptomycin has been found to have very little value against bone infections, except when used in conjunction with surgery where there could be direct application.

Thus far it has not given dramatic results in peritonitis, but its continued use as an auxiliary treatment seems justified.

In various dysenteries, due to susceptible bacteria, considerable benefit has been noted.

sometimes when the drug is given by mouth alone.

The substance has little value against typhoid fever and it is apparently of no use in controlling carriers of this disease.

Excellent results have been obtained with direct application of the drug to infections of the external ear, the pleural cavities and the brain.

Serving Hospital Meals Attractively

BARBARA BELL

Food is not only one of the vital necessities of life but, also, as much a curative agent as many medicines. To the hospital patient the meal tray marks off the important events of the day. It may be eagerly awaited or casually and indifferently accepted. The thoughtful department will attempt an attractive and compelling presentation.

The attractiveness of the tray de-

pends upon:

Seasonability: The weather exerts a definite influence on both the appetite and body needs. Recognition of the debility produced by hot weather should be shown in summertime meals. Simple foods, interesting in color and fresh in form and texture, with a combination of chilled or frozen dishes, should generally, but not completely, replace those rich in fat and energy value. Some foods are definitely substandard at certain times of the year, e.g., grapefruit is inferior in texture and flavor from June to October, so should not be used extensively during these months.

Meal planning: Planning menus for a definite cycle of time has proven an efficient means of obtaining meals of maximum interest. Provision should be made for considerable flexibility. "New dishes beget new appetites," according to John Ray. "New dishes beget new Monotony should be avoided by limiting the use of any particular food constituent to once in any given meal. For instance, cream of tomato soup and sliced tomatoes should not be served at the same time. If a food appears in two successive meals it should be presented in markedly different forms. Variations are obtained by serving food raw or cooked, peeled or unpeeled, or cut into different shapes and sizes. Consideration of color helps avoid monotony and provides interest in the meal.

Food preparation: Food prepara-

tion conserves the nutritive value of the food, improves its digestibility, enhances its flavor and palatability, and retains the attractiveness of its original color, form, and texture. Quick cooking of vegetables and fruits, with a minimum exposure to air, results in the least loss of nutrient elements. Cooking in small quantities allows for heat penetration throughout the mass without over-cooking with the consequent loss in food value and original flavor. The volatile substances that produce the flavor may be driven off or changed to other compounds less enjoyable; for example, the undesirable effect of long-continued cooking on cabbage and cauliflower is well known.

The effects of cookery on color, form, and texture are also important factors in the palatability of food. The preparation should be focussed on maintaining the color found in the original state of the food, such as the green in beans and the red in beets. Foods may be prepared so that the original form is maintained or another form as pleasing is produced. Baked apples, boiled potatoes, and broiled steak are examples of food which, if well prepared, should show little change in their original form. Sliced or diced vegetables and all "made" dishes show changes in form from that of the original food or ingredients used. The slices or forms should be uniform in size, thickness, and shape to lend ease to serving and The form of the slices or other shapes should be apparent as such and not be a conglomerate mass.

Texture may be maintained in the natural state, softened as in fruits and vegetables, or hardened as in pastries, batters, and doughs. The food preparation should maintain or develop the texture considered characteristic of a given standard product, whether boiled potatoes or cake. Due thought is not always

APRII., 1947

given to the influence exerted by the form and texture of food upon the attractiveness of the tray service; for example, salad ingredients too finely shredded, the creamed dish with a "pasty" consistency, carrots and turnips cut into pieces too large for daintiness, meat that looks scrappy, and potatoes so large they appear to dominate the plate.

In serving fresh fruits and vegetables the cleanliness, crispness, and freshness, together with its appeal in color and form, either natural or achieved, affect the attractiveness.

Chilling is important in the preparation of many dishes. All fruits and vegetables to be served raw are more palatable when properly chilled. The old adage, "Serve hot foods hot and cold foods cold," cannot be ignored in successful food preparation.

The problem of satisfactory vegetable service is particularly difficult. Keeping cooked fresh vegetables on steam table for several hours before they are served destroys the color, vitamin content, and palatability. Vegetables should be cooked in small quantities so that the steam counter, is replenished with freshly cooked food so as to act as a point of service rather than a place of storage.

Tray service: The type of tray used should be of such material that it is easily kept clean and is not readily marred by constant usage. It should be sufficiently large to accommodate the meal planned, with-

out appearing crowded.

For most people the attractiveness of the service is determined by the use of clean linen, freshly and carefully laid. When paper tray-covers are used extra care is required to prevent them coming awry on the smooth surface of the tray.

All silverware must be durable and serviceable and at the same time attractive in line and design. Well-kept silverware lends charm and dignity to the service. Constant attention is necessary to remove tarnish and stains of various kinds.

In one hospital it was found

possible to reduce the number of employees by the use of paper dishes. This change in standards might be accepted without protest but only under emergency conditions. Conservative but attractive designs of vitrified china seem the most suited to hospital use. Gaudy designs in the centre of the plate appear to leave little room for food. The glassware should be of good quality. It is important that china and glassware be well washed and shining and that those pieces chipped or cracked be removed from service. The effect of an otherwise attractive meal will be spoiled by damaged or poorly washed tray equipment.

The portions of food served should be such as appeal to the appetite. Small amounts, pleasingly arranged, revive the jaded interest in food. With a little thought and imagination an artistic piece of work can be accomplished. As in the words of Shakespeare, "They are sick that surfeit with too much, as they that starve

with nothing."

One of the old and recognized means of serving attractive trays is by the use of flowers. These are not always available. Name-cards and materials from the woods can be ingeniously and inexpensively used to add charm and interest, with variations to fit special days, anniversaries, and seasons.

Every patient is an individual with likes and dislikes, peculiar complications, special needs, and variations in ability to use certain foods, and the tray service must take the individual into consideration. Therefore a psychological understanding and sympathetic approach toward the patient is necessary. Some one has said, "After a good dinner one can forgive anyone, even one's own relatives."

BIBLIOGRAPHY

West and Wood. Food Service in Institu-

Cooper, Barber, Mitchell. Nutrition in Health and Disease.

Bedside Nursing - An Essential Service

CHRISTINE E. CHARTER

IF IT WERE possible for everybody in Canada who needs nursing care to secure it, the nursing profession would not be nearly so concerned as it is at present with self-analysis.

The problem which is disturbing most of us is the desire for change. The general public will not be satisfied with pre-war standards of medical care — they want good medical care, including nursing services, extended throughout the Dominion. For proof of this we have only to think of hospitals, large and small, crowded to capacity; of the growth of graduate staff nursing in hospitals; of the great demand for private duty nursing; of the increase in bedside nursing visits made by the Victorian Order of Nurses, or of the trend towards giving more bedside nursing service by official public health agencies. We realize that there is extremely uneven distribution of nursing care: we know that the need for change is being felt generally, also that such a need may shortly become a demand and that demands usually result in action. It is for us to decide whether some action to provide this essential service is to be taken by us as a professional group or by lay bodies or by both. While lay groups might possibly be more concerned with quantity of service, we, as nurses, should surely make the most of our opportunity to see to it that the quality of nursing care is emphasized in any plans which may be made.

There is evident at present a feeling that, before more adequate service can be provided for the public, changes must take place within the profession itself. If this be so, each nurse should know very clearly in what direction she wants change and how it is to be obtained — whether by coercion or by the democratic method which, surely, if somewhat slower, produces better and more lasting results in the end.

We should each know what has already been accomplished and should have some concrete suggestion to offer regarding what more we think should be done. In other words, through our own existing organizations we should study proposals, legislative and otherwise, which will affect both the medical and nursing care of the Canadian people as well as our own interests.

One of our greatest problems is in bringing together the people who really need each other — in relating the skills, experience, and personal preferences of the nurse on one hand, to the needs and geographical position of the employer (hospital or individual patient) on the other. As a beginning it might be useful if each community could assess its own available resources and methods of supplementing these resources. Nurses, often forming one of the largest professional groups in a community, could certainly find much to do along these lines, both in investigation and in the interpretation of findings to the community. In centres where such surveys have been made one is immediately confronted, of course, with the actual shortage of nursing personnel, which brings us directly to the question of why so many nurses turn from the bedside nursing for which they were trained to other branches of the profession.

The Victorian Order of Nurses provides a combination of bedside care with public health nursing, and affords ample opportunity for one to hear reasons pro and con bedside nursing as it affects the nurse herself either in an organization or a hospital. Financial security and hours of work have been discussed frequently elsewhere so I would mention briefly a few of the other comments sometimes heard. One is that there is less opportunity for ad-

APRIL, 1947

vancement and for keeping up-todate in the bedside nursing field than in other phases of the work. Educational opportunities are as much desired by the nurse giving daily care to a patient as by the nurse teaching or supervising. Facilities for greater variety of clinical experience in different parts of the country would be appreciated by some nurses; more of the effective in-service programs already in existence in some hospitals, with planned staff education; conferences with, perhaps, renewed emphasis on the needs of the individual patient; and libraries, are all projects to which each nurse can contribute and which, in smaller centres particularly, will help to keep her abreast of the times and enthusiastic about her own field of work.

Another objection, expressed perhaps more frequently of visiting nursing, is that the case load is sometimes largely made up of the Visiting nursing chronically ill. organizations give care to acutely ill patients in their own homes on a part-time basis, and these medical. surgical, obstetrical, or communicable disease cases do undoubtedly require professional nursing, but it is true that for various reasons a great many people suffering from chronic illness must also be cared for in their homes. Theoretically, such care is given by the nurse only until the family can give it adequately or until other arrangements can be made. It would seem that by relieving professional nurses of many hours of tedious care that can be given equally well by practical nurses or nursing aides, each graduate nurse could use her special skills and training to greater advantage as well as extend her activities over a wider area. The practical nurse could assist without ever being totally responsible for the complete care of any patient. The patients whom she visits alone would be those with long-term or minor illnesses, who, at the time of her visit, require little or no teaching and whose needs at that time can be filled satisfactorily by the practical nurse. Nursing still fears the encroachment of the subsidiary worker in the fields of private duty, institutional, and visiting nursing, and this step should, of course, be contingent upon the proper training and licensing (provincially) of the practical nurse. However, the volume of service required to provide all our people with good nursing care requires, too, that the service of professional and practical nurses must be so planned that each type of worker can have the satisfaction of giving the type of service for which she is qualified.

Again, much time is often spent by the bedside nurse in clerical duties. Clerical time is still somewhat cheaper than nursing time, although a good worker of this type is almost equally difficult to obtain. Making provision for removing all purely clerical tasks from the nurse would again free more of her time for that work for which she was The same holds actually trained. true about the employment of maids, possibly on a part-time basis, by the larger organizations at least. A maid who cleans a nurse's bag or hospital equipment is saving time and money for the agency or institution, while the nurse would not feel that she was once more doing something which, though necessary, could be managed equally well by an unskilled person.

Turning back to look at the problem of providing an essential service from the general point of view, organized nursing is we know, acutely aware of the insecurity of many nurses, of the fact that salaries are too small for their needs and insufficient reward for their trained skills. Yet nursing costs are becoming too great for the public to bear, and now, in common with several other countries, we have reached the time for re-organization. Doctors, nurses, and the public must agree on the best way to supply medical and nursing care to everybody, with due consideration for each group involved, whether by a contributory scheme of health insurance or by some other method. Whatever the method it will require more nurses to do bedside nursing than are at present available. In this period of unrest do we first of all need to examine our own attitudes and rediscover that enthusiasm which sees in each patient the opportunity to study and serve an individual and through him a nation? A recent editorial in *The Canadian Nurse* said of bedside nursing: "The actual day-

by-day care of sick persons is the most exacting, the most difficult and in the long run the most satisfying." Whatever the method, it will require co-operation and co-ordination within our own profession, the simultaneous action of groups studying and working and planning together to enable us to become a force for initiating a new quality of health in our country and security in nursing.

Enrolment in University Schools of Nursing

WITH the need for qualified personnel in our hospitals and public health organizations greater than ever before in the history of nursing in Canada, interest is focused on how many persons are enrolled in the various university schools and departments of nursing across the Dominion. In order to have accurate information, the Canadian Nurses' Association sent a questionnaire to

each of the universities which enrol students for either undergraduate or post-graduate nursing courses. The accompanying tables present the summary of the information received for the session 1946-47.

A total of twelve universities in Canada include courses in nursing in their calendars. Some provide undergraduate courses and experience (1); others enrol only graduate nurses

TABLE I
Universities with Schools and Departments of Nursing

	(1)	(2)	(3)
Alberta			X
British Columbia .			7
Manitoba		Χ-	
McGill		\	
McMaster.	`		
Montreal		\	
Ottawa			V
Queen's			\
Saskatchewan	\		
St. Francis Xavier	\		
Toronto			N
Western Ontario.			χ-

TABLE II
Undergraduate Nursing Students

	1st yr.	2nd yr.	3rd yr.	4th yr.	5th yr.	Totals
Degree course —veterans	15	3		2		20
others	170	94	86	66	74	490
Diploma course—veterans	3					3
others	62	63	59	8		192

(2); the remainder make provision for both (3). Table I indicates the types of courses available at the various universities.

Table II shows the number of students registered in the various undergraduate years, including both those who are attending university and those who are having their hospital experience. In order to determine how many veterans have entered the university undergraduate courses in nursing, a separate listing was made for this group. Twenty-three veterans are enrolled this year. Diploma courses as distinct from degree courses are offered by some universities and are indicated separately. A grand total of 192 students are registered.

University post-graduate courses have attracted large numbers of

TABLE III
POST-GRADUATE NURSING STUDENTS

	Degree Course		CERTIFICATE COURSE		DIPLOMA COURSE		TOTAL
	1st year	2nd year	1st year	2nd year	1st year	2nd year	
A.	2	1.3	11	6			32
В.		11		5			16
C.			4				4
D.	1	14	42			3	57
E.		11	10	3			24
F.				6			6
G.			50				50
H.	6	19		4			29
I.	9	11	56	6 *4	21		103
J.	. 34	19	294	*11		1	347
K.			14				14
L.	9						9
	61	98	481	30	21		691

^{*} Included in undergraduate course.

A. Administration in schools of nursing; B. Administration in hospitals; C. Administration and supervision in public health nursing; D. Nursing education (general); E. Nursing education (advanced); F. Clinical supervision (hospitals); G. Supervision (special fields); H. Teaching in schools of nursing; I. Supervision in schools of nursing; J. Public health nursing (general course); K. Public health nursing (advanced course); L. Other courses (not specified).

graduate nurses this year. The majority of this group have enrolled in the one-year certificate courses. the public health nursing elective predominating. The total enrolment of veterans in these various courses is much larger than in the under-graduate picture. There are 255 veteran nursing sisters registered in the various certificate courses, 2 in the diploma course, and 38 in the degree courses for a total of 295. This figure represents 42.69 per cent of the enrolment in post-graduate Table III gives a picture courses. of the wide variety of courses that are included and of the number of students in each. The table is divided to indicate the numbers working toward degrees, diplomas and certi-

ficates, either in their first or second

The universities report that large numbers of applicants, including nursing sisters, have already been accepted for the new session commencing next September. Prospective post-graduate students who have not yet filed their applications are recommended to make their plans as early as possible to avoid disappointment. Certain limitations in the number of students they can accept are imposed upon university schools and departments of nursing by the facilities for field work which are available. Many organizations and associations have scholarship funds for post-graduate study. Nurses are advised to make early application.

The German Nursing Services, 1945-46

MABEL G. LAWSON, M.A., M.B., Ch.B., S.R.N.

THE PICTURE presented by the German Nursing Services in the British Zone of Germany in July, 1945, was one of considerable disorganization. Hospitals had suffered badly from bombing; existing accommodation was grossly overcrowded, and, in many areas, there was no adequate water supply or sewage system; there was a deplorable shortage of soap, dressings, drugs, and equipment of all kinds; nursing staffs were mal-distributed; and many socalled "matrons," who had held important and responsible positions under the Nazis, had no proper This state of affairs was training. fully appreciated by the majority of the profession, but hitherto in Germany the nursing profession has had little say in its own organization, and nurses have not enjoyed the same privileges, or attained to the same status, as their colleagues in countries where nursing is regarded as a sister profession to that of medicine.

The majority of nurses continue to be trained under the Motherhouse system, whether Catholic, Evangelical, or Red Cross. While this system develops to a high degree a vocational outlook, it does not encourage the development of qualities of leadership, and a good deal of understanding and encouragement was required to overcome existing prejudices and obstacles towards advancement, not the least of which were provided by the attitude of the German medical profession.

Certain broad lines of development were adopted to cover the work of hospital nurses, midwives, district nurses, and public health workers, the first essential being to obtain a measure of unity within the profession itself, and to secure some form of organization through which to work. This was done as follows:

1. A German Nursing Advisory Committee was set up in each province (five in all in the Zone) to consult with the Control Commission Nursing Officer on affairs of local concern, or to deal with specific matters referred to it for recommendations.

2. Five German Nursing Officers were appointed, one to the public health department of each Provincial German Civil Government. Each of those chosen represented a different approved association of nurses, so that representation of all denominational groups was secured.

3. A German Zonal Advisory Nursing Committee was instituted, meeting monthly at Control Commission Public Health Headquarters. It consisted of five Nursing Officers (see No. 2), together with representatives of midwives and of public health workers. It worked in close association with the corresponding German Medical Advisory Committee, and dealt with matters concerning the profession as a whole. The general opinion of the profession was obtained through the Provincial Committees.

4. The appointment of a German Liaison Nursing Officer to work from Control Commission Headquarters, and to co-ordinate the work of the above committees and officers, had been sanctioned, and the German Advisory Committee had put forward suitable nominees.

In this way a set-up, somewhat comparable to our General Nursing Council, was achieved and there was created a body which was encouraged to tackle the problems of re-organization, and which was responsible to the nurses themselves for the recommendations it made.

These committees were advisory only, and any action consequent on their recommendations was initiated by Control Commission officials. The sort of things with which they dealt were: Standardization of training and examinations for the State Registration Certificate; control of the assistant nurse; regulations governing midwifery training; ratio of nurses to patients; holiday entitlement for various nursing grades. The period of training for general nurses was increased to three years throughout the British Zone as from April 1, 1946, a step which had the unanimous support of the profession.

Of great importance was the reconstitution of the professional organizations. Those representing respectively the Catholic nurses and the deaconesses had never entirely ceased to exist, although all their activities were in abeyance, but the Free Nurses had been compulsorily absorbed into the Nazi nursing organization, while the Red Cross, being a para-military formation, had been completely dissolved by the Occupying Powers. It is only fair to say, however, that large numbers of trained Red Cross sisters were never party members, and had taken no part in politics. This was, of course, true of many other members of the nursing profession. The role played by these professional associations, together with the associations of midwives and of public health workers, is a very important one in Germany, and their re-constitution gave great satisfaction to nurses. It was, however, absolutely essential to bring these groups into closer relationship than had previously existed between them and, to this end, the Provincial Nursing Committees were of great assistance.

One or two other developments must be mentioned briefly. The wellknown post-graduate nursing school, Werner Schule, belonging to the German Red Cross, and formerly in Berlin, was re-opened in Göttingen with the help of the university authorities there. Lack of accommodation limited the number of students for the first six-month course, but it was hoped later to increase the number, and to include nurses from other professional groups, thus providing a nucleus of specially trained nurses for higher administrative and teaching posts.

Refresher courses in the larger cities were inaugurated and were received with great enthusiasm. Travelling, ration, and housing difficulties did not then permit of any but day courses but, in addition to the professional interest, the courses brought together nurses of all groups and denominations working in the same area, and gave them an opportunity of discovering and discussing each other's problems. The Draft Constitution and By-Laws for affiliation

to the International Council of Nurses sent me by Miss Schwarzenberg was given to the Zonal Advisory Committee for future consideration. The difficulties of membership, in the absence of a national association, were appreciated, but efforts were being directed towards securing professional unity in the British Zone as a preliminary towards future development.

Space does not permit of any details, or of descriptions of other aspects of nursing dealt with, such as school and maternity and child welfare services. Difficulties of every description were not inconsiderable, and the sense of frustration was at times most acute, but, looking back, there were many bright

spots. I endeavoured to adhere to two guiding principles which I had set; firstly, to help the German nurses to assume greater responsibility for their own affairs, and to develop greater independence; secondly, to bring the various denominational and ancillary groups into closer professional relationship.

The desire of the German nurses to bring themselves into line with professional developments in other countries was very genuine, and they co-operated freely and in a whole-hearted manner, although many of the suggestions made were new to them, and difficulties and prejudices had to be overcome. While much remained to be done, a good start had undoubtedly been made.

A Permanent Home

The School for Graduate Nurses, McGill University, now occupies part of the spacious and attractive residence of the late Sir Edward Beatty located at 1266 Pine Avenue, Montreal, which recently has been bequeathed to the university.

The greatly increased enrolment of students demanded much more space, and the school is fortunate in now possessing two large classrooms on the top floor which can accommodate two hundred and more students. The larger room, facing the south, which was a sunny solarium, affords a lofty panoramic view of the city. The library is also spacious. Upon entering, one is affected by the quiet, attractive environment, which is conducive not only to concentration but to browsing and meditation. The walls are panelled walnut and a beautiful rug adds to the harmony of color. Set-in book cupboards surround the room, filled with a fine collection of books with sufficient additional copies to satisfy the needs of a larger number of students. The class of 1946 left a generous gift of money for this purpose. At last the accumulations of professional magazines, reports and documents of all sorts, have found suitable resting-places on shelves specially designed for convenient use. The school has added substantially to its library in the last two years, and it has reason to be proud of it.

The new location takes the students away from the university cafeteria and other suitable eating-places, but nurses have the happy faculty of making the best of situations. They have made friends with the milkman, the baker—and, perhaps, according to the rhyme, the candlestick-maker—who call daily and leave supplies. The honor system of "help yourself and pay for what you take" evidently works satisfactorily for all concerned. The serving-kitchen and lunch-room are busy and crowded places at the noon hour.

The school has been very fortunate in receiving a gift of sixty thousand dollars from the W. K. Kellogg Foundation for the purpose of meeting increasing demands and for the expansion of the school program during a three-year postwar period. With this additional financial assistance beyond the university budget, the school is in a position to increase its educational resources, to secure additional staff, and to carry out more effectively the two-year courses leading to a Bachelor of Nursing degree. Another objective is to continue the organization of clinical services for post-graduate experience. Two post-graduate courses, in the fields of psychiatric and obstetrical nursing, have been established, and the co-operation of nurse administrators and supervisors in these fields towards



Miss Stanton and Miss Peverley on the Staircase

Peter Hall

planning sound clinical programs is greatly appreciated. This spirit and effort gives encouragement to undertake further organization.

The difficulty of securing practice teaching and field-work facilities for an enrolment of 130 students this year is a problem common to all university schools. This situation in the McGill School is made less difficult because of the understanding and whole-hearted assistance of heads of schools of nursing and of public health nursing agencies, together with

their staffs, in accepting and supervising students at a time when organizations with limited nursing personnel are strained in an effort to maintain their standards of nursing service.

There is evidence of another maximum enrolment next year. Ninety returned nursing sisters are in attendance this session, and many other eligible applicants who served overseas could not be accepted because of lack of accommodation; they will be considered for the session 1947-48.



The Library

Peter Hall

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Public Health Nursing in Prince Edward Island

ELEANOR R. WHELER, B.A.

If you want to find real happiness you should be a public health nurse in Prince Edward Island, which, as one Islander puts it, is the smallest yet the grandest of all the prov-What a blissful inces of Canada. change it was for me, to go from the roar and rush of the modern city to the beauty and peace of this "Garden of the Gulf!" The countryside with its charming farm-houses and well-kept farms, all the harmonious shades of green of the various crops - the dark green fields of potatoes, the light green of the hay, the blue-green of the oats, the pale green of the turnips — with hedges of spruce trees and graceful birches along almost every fence, the red roads winding in and out, and always the surprise of a glimpse of blue sea just over the hill or just around the bend in the road, make the work of the rural nurse a joy.

I do not think you would find finer people to work with anywhere. Their kindness and hospitality never cease to amaze me. Indeed, I should like to become an "Islander." But while the sons of the Island, who have roamed far afield to fame and fortune, are still "Islanders," and bring a reflected glory to their home, unless you were born on the Island you never quite become a true "Islander" except perhaps to yourself. Do you know of many districts where, at

noon on a summer day, or at the end of the day before the long drive home, you can have a swim in the sea and a meal cooked on a bonfire on the shore to give you a little mental

and physical relaxation?

Public health nursing on the Island was begun in 1921 by the Red Cross Society. They put on a demonstration program for ten years and in 1931 the Department of Health took over the public health work. The Island, with its population of about ninety-five thousand, is served by five public health nurses doing a generalized service, one nurse doing tuberculosis work, and one nurse doing communicable disease nursing, including venereal disease work. The director of nurses was on leave during the war, but returned in October, 1946. During her absence her place was ably filled by the acting director, who, though married and with many household responsibilities, found time to give a guiding hand to the staff.

The medical staff consists of the chief medical officer, two physicians doing tuberculosis work, one of whom, in addition to his work as director of the sanatorium, holds regular monthly chest clinics at four key points on the Island, as well as weekly clinics at the sanatorium; the other devotes full time to the patients in sanatorium. A new wing

APRIL., 1947

added to the sanatorium in 1945 has a splendid new operating-room which makes it possible to do chest surgery without transferring the patient to a general hospital as was previously necessary. One physician is in charge of venereal disease work and the provincial laboratory. There is also a full-time sanitary inspector.

In 1945 the mobile x-ray unit, owned and operated by the Tuberculosis League, began its work of taking a chest x-ray of the whole population on the Island. A truck is fitted up with the equipment and moves to the various districts, setting up in a school or hall for a few days or a few weeks, depending upon the size of the community. The patient pays fifty cents for a chest x-ray and the maximum for a family of any size is \$2.50. It is hoped that the whole population will be served every three years. Through the Tuberculosis League, volunteers in every school district are asked to visit the whole community, making appointments and arrangements for transportation to and from the centre for those without their own means of transport. The plates are all read by the chest specialists at the sanatorium. Of the thirty-five thousand plates taken to date, 5 per cent have been found with active tuberculosis. The large percentage of these are minimal cases and so their prognosis is good. However, many who had never been under medical care have been found with moderately advanced or even far advanced disease, some even with positive sputum. All the cases and suspects are asked to come to the regular chest clinics, or to special clinics as the case demands, for a clinical examination. Both the tuberculosis nurse and the district public health nurse assist at all the clinics. The cases are followed up in the home by the tuberculosis nurse, assisted from time to time by the district nurse. Despite the addition made to the sanatorium, there is still quite a long waiting list for admission. Up to the present time the x-ray of the chest has been on a voluntary basis, and the response of the people has been very good, though not 100 per cent.

Venereal disease clinics are held twice a week in Summerside, staffed by a local physician and assisted by a local graduate nurse. In Charlottetown, with the aim of getting away from a clinic, treatments are given by appointment at any time throughout the week by the director of the provincial laboratory and venereal disease control, assisted by the communicable disease nurse. The follow-up work is done by this nurse, who has taken post-graduate training in venereal disease control. During the war there was excellent co-operation from the medical officers of the Army, Navy, and Air Force stationed on the Island. A recent law, demanding blood tests and premarital examination before any marriage can be performed, should make quite a difference in the control and early treatment of these diseases.

The public health nurses, giving generalized service apart from the communicable diseases, spend a great part of their time in school work and its follow-up. In my district I have ninety-eight schools, eightytwo of which are one-roomed schools and sixteen of which vary from two rooms to twenty-six rooms. My school population is about forty-five hundred children, which makes a heavy load with long gaps between visits. At these visits the children are weighed, measured, have vision and hearing tested, throats, teeth, breathing, posture, etc., inspected. A note is sent home with each child giving the parents a report of the findings. On the back of the note is an excellent bit of advice on the correction of defects and the reasons for prompt treatment, as well as general advice on diet, rest, recreation, and immunization. Follow-up visits are made to homes where there are pro-An effort is made at this time to visit pre-natal cases, infants, and preschool children in the district.

In some parts of Canada, nurses feel hampered in their work by the lack of treatment facilities. Here on the Island the Red Cross has a

very well organized plan for assisting needy families, with hospitalization for tonsillectomies and provision for eye examinations and glasses. The family physician or the eye, ear, nose and throat specialist is always willing to look The Red Cross after these cases. also holds crippled children's clinics - assisted by the Rotary Clubs of Charlottetown and Summerside staffed by an orthopedic surgeon from Halifax who visits the Island twice These clinics are well attended, patients being sent in by the family physician, public health nurse, or just coming on their own initiative to seek help and guidance. Junior Red Cross nurse and the public health nurse of the district attend the clinics, which are held in both Charlottetown and Summerside, and do the follow-up work. Reports are sent to the family physician. Operations may be performed and plaster casts applied in the local hospitals. In special cases the patient is taken to hospital in Halifax, the Red Cross paying the hospital bill for indigent cases.

Vaccination against smallpox is compulsory for school attendance. The town schools are visited yearly for this purpose, and the rural schools every three years by the chief medical officer. Infants and preschool children are invited, but the large percentage of vaccinations are to school children. The law also requires revaccination of children twelve years and over attending school. Needless to say, there is no smallpox on the Island.

Diphtheria immunization is done every year in the town schools and every three years in the rural districts. Toxoid is administered both by the chief medical officer and by local physicians who receive an honorarium from the Health Department. More and more infants and preschool children are receiving this protection. In 1945, 3,383 preschool and 2,213 school children received three doses of toxoid.

Last year, my first on the Island, I had to make three visits, and occasionally four, to each of my ninety-eight schools to assist with giving the diphtheria toxoid. needles and syringes are boiled on Sterno stoves and set up on sterile paper towels. Some of the doctors of seventy-five or even eighty years of age were still anxious to attend the toxoid clinics. One day we were taking a short cut through the hills to our last school. We climbed a narrow, winding road to the top of the hills where we looked down at the "Devil's Punch Bowl." The view was wonderful but, at the top, imagine my consternation in finding a washout in the road and a hole about four feet deep! We had come about a mile and a half along this road and there was no place to turn the car so I started to back. I was successful at staying on the road for about half a mile but then looked up for one second and was off into the I had to walk the other ditch. mile to the nearest farmer who came with a horse to pull me out. What excitement we had after he got me back on the road, backing to a spot where, with spruce boughs over the ditch and a rail fence taken down, we were able to turn the car and go the long way around, where the people were still patiently waiting.

Another interesting toxoid day we took a visiting teacher with us. She sat in the car and gave us an account of a toxoid clinic from the outside looking in. One mother got her five-year-old son as far as the schoolyard. There he lay down, kicked and screamed and put on such a successful temper tantrum that she took him home. Another mother, whose preschool boy was walking along quite amiably, gave him a shake outside the door and said, "Don't you dare cry in there in front of all those people. You walk in like a man!"— and he did!

Child health centres are held weekly in the larger centres, and my Friday afternoons with the babies are perhaps my happiest times. The young mothers are so appreciative of advice and it is such a joy to see babies well-fed, well-cared for, and happy.

I wish you could have seen Willie. who made his first visit when he was only three weeks' old, weighing only 5 lb. 3 oz. (I would have had him in an incubator!) His mother was only sixteen years old and her knowledge of babies was rather limited, but her eagerness to do everything for wee Willie certainly brought results. Now he is six months old, weighs 16 lb. and laughs out loud every time you talk to him. He has two very charming dimples and black curls all over his head. His mother is one of my best advertisers. I am even getting mothers from ten and twelve miles

away, friends of hers, who come in by bus to the baby conference.

While much is being done to improve the health of the people, and while the infant mortality and tuberculosis death rates, often an indication of the effectiveness of the program, are improving, still our nursing staff could be doubled or even trebled and we would still not be over-staffed. With an increasing interest in health and preventive medicine, we all hope that the day is not too far distant when the people will be willing to pay a bit more for health services for the community.

Immunity to Mumps

Thirty per cent of people probably have had mumps without knowing it. The result has been a high degree of immunity to epidemics of this common, but sometimes quite serious, disease of childhood. Such is the conclusion from studies of fifty groups of children and adults conducted by University of Pennsylvania and Harvard University medical scientists. Mumps and measles usually are paired as childhood maladies. Each is caused by a specific filterable virus. Both diseases are very contagious. One virus presumably is as widely disseminated in the population as the other. Yet the studies show that about 33 per cent of young adults have a probable acquired immunity to the disease indicating some past infection of which they were unaware. One attack of mumps is believed to protect an individual against further attacks of the virus for the rest of his life. Statistical studies have shown that whereas about 90 per cent of the population suffer from measles at some time or other only 60 per cent are victims of mumps. The immunity of a person was determined by the so-called "complement-fixation" test of the blood serum with mumps virus cultivated in incubated chicken eggs, and also by a skin test with similar material. The reasons why mumps should attack some persons in such a mild form that it is not recognized-it may amount to no more than a slight headache or an "out-of-sorts" feeling-is unknown. The technique of determining immunity may prove of considerable value in times of mumps epidemics when the relative susceptibility of a

population can be determined before undertaking defence measures.

-News Notes No. 55

Australian National Memorial

In October, 1945, the Australian Nursing Federation wrote to the Prime Minister asking him to initiate and sponsor a Commonwealthwide appeal for funds to provide a national memorial for members of the Australian Nursing Services who were killed or succumbed to illness or ill-treatment in the recent war. The form of memorial suggested was the establishment of post-graduate courses with the ultimate aim of an Australian College of Nursing.

A reply has been received from the Prime Minister stating that . . . it was not a project which they could advise officially. The Prime Minister advised that it has been decided that the national tribute should be centred at the Australian War Memorial in Canberra and that it is considered that any regional or sectional memorial should be financed by public subscription.

— The Australasian Nurses' Journal

The Indian population in Canada has increased almost 10 per cent in the last reported ten-year period.

Most of the 7,205 Eskimos in Canada are essentially coast dwellers, obtaining much of their food and clothing from the mammals of the sea.

INSTITUTIONAL NURSING

......

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Personal Interview

Lois Lethbridge

In considering the subject of the personal interview let us divide the topic into four parts: application, use of the placement service, references, and interview.

APPLICATION

In applying for a position the two methods generally used are the written application and the personal interview. Frequently the second follows the first.

The letter of application may be either in long hand or it may be typewritten. Some employers prefer a letter written in the applicant's own handwriting as they feel that from this type of letter much can be gathered regarding the applicant's personality, ability, etc. This letter should be clear, concise, courteous, and correctly spelled. A good grade of plain paper should be used. The letter should contain: (1) a definite statement of application for the position; (2) reasons for making application; (3) credentials — including education, experience, and other qualifications, listed in chronological order; (4) a few important references; (5) brief but explicit information concerning age, nationality, religion, and matrimonial status, and, finally, (6) a request for a personal interview. This last is important as it brings the nurse to the attention of the employer as a definite personality.

If a record report is to be sent from the Placement Bureau it will not be necessary to repeat all the details of experience in the letter.

PLACEMENT BUREAUX

In many of the provinces, Nurse Placement Bureaux have been established which have proven to be of great benefit both to the individual nurse and to the employer. The use of this bureau offers many advantages to nurses. These include: accurate and up-to-date lists of vacancies, with details regarding the terms of employment; counselling and guidance regarding the type of work for which the applicant's preparation, experience and ability best suit her, and suggestions for future post-graduate study to prepare her for more advanced positions. Another advantage of which she may avail herself is the introduction to an employer. This may be in the form of a personal interview which is arranged for her, or by a letter sent to the prospective employer containing her qualifications and places of past employment.

REFERENCES

Most authorities agree that there should not be less than three or more than five references and that these should be from people well qualified to judge the nurse's scholarship, ability, character, and personality. It is not considered wise to include relatives or close friends. Particularly acceptable are letters from instructors and former employers. Most

APRII , 1947

employers, seeking information about applicants, prefer to write directly to the individuals whose names are given. Therefore, give the complete addresses of all references. Letters headed "To Whom it May Concern," are generally of little value. It is wise to first obtain permission before using a name as a reference. Failure to do so shows lack of courtesy and may result in embarrassment and misunderstanding.

PERSONAL INTERVIEW

In the application for any position the personal interview plays a very important part, not only from the standpoint of the employer but also from that of the applicant. The employer may learn a great deal about the applicant's personality and habits while the applicant in her turn has the opportunity to judge the "spirit" of the institution, the people with whom she would work, and the prospects for growth or advancement.

To the applicant: Preparation for the interview by the applicant is important. This may be done by thinking through the issues that may be brought up so that she will be able to reply to the best advantage. Plenty of time should be allowed to arrive at the appointed hour without having to hurry. This will help to relieve the nervousness that it is natural to feel at this time. must wait, she should do so with good grace. Be courteous to everyone. Be careful of the impression created. Good grooming is essential. includes conservative dress, immaculate cleanliness, well-manicured nails, and carefully arranged hair. be conscious that she is looking her best helps to create a feeling of selfconfidence. The interviewer will pay careful attention to diction, tone of voice, posture, alertness, and ease of manner. The latter may be acquired by simply acting naturally. Poise and not pose is the important thing! Cultivate a pleasant expression. A heart of gold and feelings of friendliness are of little value if the expression resembles the proverbial "meat axe." Remember that

when admitted to the interviewer's presence it is a poor start to address a prospective employer by an incorrect name, title, or address.

It is best to let the interviewer ask the first leading questions. This will give the nurse time to study her and decide what she wishes to say. Answer all questions clearly and honestly, endeavouring to keep in mind the essentials. "Yes" and "No" answers are generally to be avoided, but care must be taken not to be too wordy. It is well to remember that there is a difference between enthusiasm for the work and effusiveness. The nurse should expect to be informed about the duties of her position and what her responsibilities would be. She should find out what salary she may expect and how it compares with the salaries in positions of like responsibility. She should be informed of the salary advancement policy of the organization and the opportunities for promotion, the internal personnel policies, such as leaves of absence, sick leave, hours of duty, and vacation. If these policies are outlined at this time, disagreement about them at some future date is very unlikely to occur. It is important to find out what perquisites in addition to salary may be expected, that is, if maintenance is supplied, does it consist of board, room, and laundry? It is quite in order for the nurse to ask to see the residence and one of the rooms occupied by nurses.

No matter what the outcome of the interview, the interviewer should be thanked for her courtesy in giving her time., If the nurse is interested in the position, she may ask if she may have time to think over the matter. If she is not interested, she should say so frankly and state her reasons.

To the interviewer: To make the interview a success preparation on the part of the employer or interviewer is also essential. This will include deciding just what she wants to accomplish by the interview, such as, finding out as much as desired about the applicant, making the appointment, and providing a suitable

place in which to hold it. Contributing to her success as an interviewer will be friendliness, frankness, sincerity, a sense of humour, and the ability to see things from another's point of view.

Open the interview with a cordial greeting and a few irrelevant remarks. This will help to break down the applicant's reserve. Questions may then be asked in a business-like manner. Encourage the applicant to talk and listen attentively to what she has to say. Two helpful facts to remember are that a good interviewer listens far more than she speaks and that observation is the twin of listening. If it seems advisable to take notes do so after explaining to the applicant that a few pertinent points would be helpful for future reference. The termination of an interview is sometimes more difficult than the beginning; and a great deal will depend upon the understanding of the interviewer who usually indicates when the interview is over. Sincerity and courtesy, however, on the part of both applicant and interviewer, together with a natural manner, are usually sufficient to ensure a favorable leave-taking.

BIBLIOGRAPHY

- 1. Braund, Elizabeth. Provincial Placement Service. *The Canadian Nurse*, Feb. 1945.
- 2. Hansen, Helen F. Professional Relationships of the Nurse.
- 3. Spalding, Eugenia K. Professional Adjustments in Nursing.
- 4. Torrop, Hilda M. Your First Job. American Journal of Nursing, April 1941.
- 5. Triggs, Frances O. Personnel Practices in the Nursing Profession. *The Canadian Nurse*, Nov. 1946.

Coming Events

(1) Alberta Association of Registered Nurses

Event: Annual meeting. Date: April 18 and 19, 1947.

Place: Palliser Hotel, Calgary, Alta.

(2) Registered Nurses' Association of Nova Scotia

Event: Annual meeting,

Date: June 11 and 12, 1947.

Place: Halifax, N.S.

Special note: Dates of meeting changed from previous notice.

(3) Registered Nurses Association of Ontario

Event: Annual meeting.

Date: April 23, 24, 25, 1947.

Place: Royal Connaught Hotel, Hamilton, Ont.

Special business: Presentation of first draft of a proposed Nursing Act.

Guest speaker: Miss Nora Frances Henderson, Board of Control, Hamilton

(4) Association of Nurses of the Province of Quebec

Event: Twenty-seventh annual meeting.

Date: May 26 and 27, 1947.

Place: Windsor Hotel, Montreal, P.Q.

Special event: Second annual luncheon meeting of all district representatives. May 26.

5 Event: Series of five lectures for industrial nurses.

Date: Commencing May 14, 1947.

Place: Montreal, P.O.

Special note: Course sponsored by Public Health Committee, A.N.P.Q.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Les Services aux Malades

GERTRUDE M. HALL

J'ai la mission de vous parler au nom de l'Association des Infirmières du Canada. Cette association est la fédération des neuf associations provinciales d'infirmières enregistrées. Elle représente environ vingt-cinq milles infirmières enregistrées du Cannada.

Mon premier devoir est de faire comprendre aux personnes présentes, lesquelles, si j'ai été bien informée, représentent diverses associations féminines. L'Association des Infirmières du Canada reconnait la responsabilité qui lui incombe, de protéger le public lorsqu'il s'agit d'employer soit des infirmières enregistrées ou des aides au soin des malades.

Durant bien des années nos efforts se sont portés à déterminer le niveau d'éducation requis par l'infirmière professionnelle et à établir un statut légal permettant au public de se protéger lorsqu'il emploie une infirmière.

Nous sommes bien conscientes que tous nos efforts pour élever le niveau de la profession ne sont pas suffisants pour protéger le public, tant qu'il sera permis à des personnes, n'ayant aucune ou très peu de formation, de prendre soin des malades.

Nous reconnaissons notre obligation envers le public, à savoir, de lui assurer un service d'infirmières. Nous reconnaissons aussi que tous les services à rendre aux malades n'ont pas tous le même caractère professionnel. Le besoin d'un groupe auxiliaire, non professionnel, pour prendre soin des malades chroniques, des convalescents, et de cas de maladie légère, s'est fait sentir bien avant que l'on parle

d'une pénurie d'infirmières ou d'employer des auxiliaires ou aides dans les

hôpitaux et à domiciles.

L'appellation, auxiliaire ou aide, comprend toutes les personnes, sauf les infirmières enregistrées, qui sont employées pour prendre soin des malades tel que, aides-maternelles, aides-malades, aides-bébés, gardes-bébés, "trained attendants," aides, Infirmières qui n'ont pas terminé leurs cours, aides qui ont obtenu leur connaissances par la pratique, sagefemmes qui n'ont suivi aucun cours, etc., aides dans nos salles d'hôpital, Les associations d'infirmières nationale et provinciales, depuis des années, discutent la nécessité qu'un permis, ou licence, soit émis à toute personne qui soigne les malades et qui est rémunérée pour ses services. Enfin en 1942, l'A.I.C. a nommé un comité chargé d'essayer de déterminer le travail, les qualifications, la préparation, le permis à l'exercice, le contrôle des auxiliaires, sous la direction d'un corps professionnel convenant à ces fins.

Un programme fut préparé afin de servir comme guide aux associations provinciales d'infirmières enregistrées. Un rapport fut adopté en juin 1944 à une assemblée générale de l'A.I.C. Ce rapport contient, au sujet de la licence ou permis de pratique et de la règlementation, l'énoncé suivant:

La règlementation des auxiliaires semble essentielle dans l'intérêt du public, pour assurer son bien-être et sa sécurité, dans l'intérêt des auxiliaires aussi afin de déterminer les normes de leur travail.

La règlementation, évidemment veut

dire, une loi accordant une licence. Il est définitivement recommandé que la règlementation des auxiliaires soit confiée: (1) A un ministère du gouvernement; ou (2) à une association provinciale d'infirmières enregistrées. Voyons quels seraient les avantages pour les auxiliaires d'avoir une licence ou permis d'exercer:

 Les normes bien définies du travail leur assureront la protection nécessaire.

2. Assurance de l'uniformité dans la préparation et l'entraînement.

3. Prévention de la compétition d'un groupe non préparé.

4. Protection du public contre un groupe

d'imposteurs.

Le "United States Women's Bureau" a publié un livret sur les possibilités du travail d'après guerre pour les femmes. Au sujet des aides, on y lit que leur travail devrait augmenter pour onze raisons, en voici un bref résumé:

1. Il semble y avoir pour l'aide une tendance à accomplir certaines charges qui dans le passé étaient accomplies par l'infirmière professionnelle, comme prendre la température et faire certains traitements de routine.

 Les hôpitaux donnent maintenant congé à leurs malades beaucoup plustôt après une opération ou après une naissance, ce qui veut dire que ces personnes ont encore besoin de soins à la maison.

3. L'augmentation du nombre de personnes agées nécessite des auxiliaires entrainées capables de donner des soins à domicile et dans les institutions.

Dans les services d'hygiène publique ou service de santé, l'expérience a

prouvé l'utilité des aides.

Le docteur Hugh Cabot, un médecin éminent en hygiène publique aux Etats-Unis, a appelé l'aide, l'associée cadette ou subalterne du personnel du service de santé. Le point important qu'il faut bien se rappeler et je le répète dans l'intérêt de la sécurité du public, c'est que les connaissances de l'auxiliaire ou aide sont limitées et que le public et les médecins ne doivent pas lui demander de rendre des services pour lesquels elle n'a pas été préparée.

Quelle différence y a-t-il, actuellement, entre la préparation d'une infirmière professionnelle et d'une auxiliaire? L'aide se prépare à son travail durant trois à neuf mois, l'infirmière professionnelle trois à six ans. Le programme d'étude de l'infirmière professionnelle est basé sur les sciences physiques, biologiques, et sociales. La chimie, la physique l'anatomie, la physiologie, la microbiologie, la sociologie, et la psychologie sont des matières inscrites au programme et leur enseignement est nécessaire pour faire comprendre les principes fondamentaux des soins aux malades. En tout le programme d'étude de l'infirmière est 630 à 1,200 heures théorie et enseignement clinique durant trois ans et son expérience clinique doit s'étendre à tous les domaines du nursing. Lorsqu'elle a terminé son cours elle doit être en me-

(1) D'observer, de reconnaître, et d'interpréter d'une façon intelligente les manifestations de la santé comme celles de la maladie: (2) de donner des soins experts dans toutes les maladies; (3) d'appliquer les principes d'hygiène mentale dans le soin des malades et de développer chez le patient l'attitude mentale qui favorisera sa guérison. Celà n'est que l'énumération incomplète de ce que l'infirmière doit être en mesure de faire. Avec le progrès rapide de la médecine, il faut que l'enseignement des infirmières soit meilleur. Tout comme la profession médicale a relayé entre les mains des infirmières bien des traitements qui autrefois étaient de la responsabilité du médecin, ainsi l'infirmière professionnelle doit analyser et confier à l'aide qualifiée les traitements et les soins que cette dernière peut donner sans danger.

L'infirmière professionnelle et l'aide bien préparée peuvent aider le médecin et tout ceux qui collaborent au maintient et au rétablissement de la santé, à assurer au public le soin des malades et les services de santé dont

il a besoin.

Mais le public peut aussi faire sa part en aidant à établir et maintenir les normes nécessaires à sa protection, les normes nécessaires aussi à la protection d'un groupe de femmes qualifiées qui continueront de servir comme auxiliaires.

Interesting People

An anniversary of particular interest was observed at Saint John General Hospital, N.B., on January 22, where Margaret Murdoch has been superintendent of nurses for twenty-five years. The event evoked widespread attention in the community, with the following editorial comment:

"On this occasion, a great many people will want to extend their congratulations and their thanks—their congratulations because she has handled her difficult duties with intelligence and efficiency, and their thanks because she has made outstanding contributions to the care of those who are ill.

"Throughout her quarter of a century of service she has taken a personal as well as a professional interest in the welfare and comfort of the patients, and she has worked indefatigably to maintain the highest standards in the hospital. Especially in recent years, her task has been complicated by the institution being constantly overcrowded, but she has dealt with the situation in a manner that entitles her to recognition and praise.

"Miss Murdoch has inspired student nurses with her own ideals and devotion to nursing. The excellence of the training given at the Saint John General Hospital is acknowledged not only throughout Canada but in the United States, and a large number of the graduates have won important positions in their profession.



Climo Studios, Saint John

MARGARET MURDOCH

"In all her efforts, Miss Murdoch has proved herself a good and useful citizen. All who know her will wish her continued success in the future."

Following graduation from Saint John High School, Miss Murdoch took her training at the General Public Hospital (succeeded years ago by today's larger and more modern institution), did private duty for six years and spent six and one-half years in the operating-room of the hospital. Subsequently, she was named superintendent of nurses which position she still capably fills.

Miss Murdoch has been prominent for years in the activities of organizations devoted to the advancement of the nursing profession and community welfare generally. She was honorary treasurer of the Canadian Nurses' Association for three terms, was president of the New Brunswick Association of Registered Nurses for eight years and was a member of its Board of Examiners. She is a past president of the Saint John Chapter of the association. At the time of the meeting of the International Council of Nurses in 1929, Miss Murdoch represented the Maritime provinces on the Grand Council.

Her interests include, as well, the Junior Red Cross, of which she is a member of the New Brunswick committee, and the Women's Canadian Club.

Appropriate gifts to mark the anniversary were presented to Miss Murdoch by the Board of Commissioners of the Saint John General Hospital, the nursing staff, the student body,



Randolph Macdonald, Toronto

MINNIE BARTLETT

and the alumnae members, as well as various individual friends and associates.

Minnie Elizabeth Bartlett has been appointed director of the Volunteer Nursing Services in the Ontario branch of the Canadian Red Cross Society, culminating many years of service with this organization. Miss Bartlett, a native of St. Andrews, N.B., graduated in 1920 from the Columbia Hospital Training School in Pittsburgh, Pa. After three years of private duty and hospital experience, she joined the staff of the Instructive Visiting Nurse Association in Baltimore, Md. In 1930, she returned to Canada and enrolled in the public health nursing certificate course at the University of Toronto. She began her Red Cross work in 1931, as charge nurse of the Outpost Hospitals. Ten years in this capacity and six years as field secretary and director of the Ontario Junior Red Cross have given Miss Bartlett the experience and insight into local problems which will prove invaluable to her in her new work.

Pauline (Metashanko) Yaholnitsky has been appointed northern supervisor of public health nursing with the British Columbia Department of Health. Born in Manitoba of Russian parentage, Mrs. Yaholnitsky graduated in 1924 from the Weyburn (Sask.) General Hospital. Brief experience in private duty and hospital staff work preceded the award of a V.O.N. scholarship on which she secured her training in public health nursing at the University of British Columbia in 1927. She returned to Saskatchewan and was in charge of an experiment for one year, sponsored by the Victorian Order of Nurses and the Saskatchewan Department of Public Health, to bring needed health and bedside nursing service to northern rural areas of the province. In 1935, she joined the staff of the Peace River Health Unit in northern B.C. Five years later, she organized a one-nurse district at Quesnel, B.C. In 1944, Mrs. Yaholnitsky enrolled for the short course in supervision and administration in public health nursing at the McGill School for Graduate Nurses, returning to the Peace River Health Unit for two years as supervisor.

Mrs. Yaholnitsky, "Yoho," as she is affectionately known to her many friends, fits in admirably to the more rugged demands



PAULINE YAHOLNITSKY

that life makes on those who work in the northerly areas. Her outdoor interests include camping, boating, fishing, and horse-back riding. Hunting and shooting small game is her favorite sport and, in season, she always carries her shot gun on her trips. Indoors, "Yoho" keeps herself occupied with books, handicrafts, and cooking. She feels that no one need suffer from boredom, even in remote rural areas—there are more interesting things to do than there is time to do them.

Ida Beatrice Brand has been appointed superintendent of field nurses in the Outpost Hospitals operated under the Ontario Division of the Canadian Red Cross Society. Miss Brand is "a daughter of the parsonage" and received her education in a number of centres in Ontario. She graduated from the



Randorph Mara naid, I. r. nto

IDA BRAND



N. Featherstone Cowley
MARGARET DULMAGE

Hamilton General Hospital in 1926. After a short period in private duty nursing, she became a staff nurse in one of the Red Cross hospitals. With a brief intermission to enable her to secure her certificate in public health nursing from the University of Toronto, Miss Brand has been associated with the outpost hospitals since 1927. Altogether, she served in eight rural centres. In 1939, she became assistant director of field nurses so has had an opportunity to develop a broad understanding of their problems and their



AILSA TURNBULL

importance in the small communities. This preparation bodes well for her future success.

Norine Margaret Dulmage has resigned from the post of director of the Volunteer Nursing Service of the Ontario Branch, Canadian Red Cross Society, which she has held since 1944. Born in Palmerston, Ont., Miss Dulmage graduated from the Toronto General Hospital in 1918. She immediately took charge of the gynecological ward there, relinquishing that post in 1923 to become instructor of nursing practice. Two years later she was appointed second assistant superintendent of nurses at T.G.H. 1930 she took charge of the preliminary students of her home school and for thirteen years was their teacher, counsellor and The eloquent tribute which was paid to her at the time she left the hospital work might well be reiterated with wider application to all the communities in Ontario where she has brought inspiration and guidance to the corps of volunteers -"True, unselfish, understanding and generous almost to a fault, with a keen sense of humor, her greatest happiness is being of service to others."

Recently, Miss Dulmage was appointed inspector of the course for nursing assistants with the Ontario Department of Health.

We are particularly pleased to welcome a private duty nurse to these pages in the person of Ailsa Turnbull, who graduated from the Royal Victoria Hospital, Montreal, in 1929. Miss Turnbull'is one of many nurses who distinguished herself with honor during World War II. The citation for the A.R.R.C., which she received as an award, reads, "Typifying all that is ideal in Canadian nursing"—unstinted praise for a job well done.

After twelve years of private duty, Miss Turnbull enlisted in the R.C.A.M.C. in June, 1941. She proceeded overseas immediately with No. 14 Canadian General Hospital. After two years in England, she was among the complement whose transport was bombed en route to Italy. There, Miss Turnbull's duties encompassed both medical and surgical wards; routine—but there was plenty of excitement to elevate it well above the borders of ordinary routine. She "enjoyed it tremendously."

Miss Turnbull has returned to civilian private duty nursing, carrying the same en-

thusiasm for bedside care well done, as buoyed her up in her war service. Her efficient skill, her personal sense of responsibility, and her charm of personality continue to make her representative of "all that is ideal in Canadian nursing."

Mildred Ileen Maybee has been appointed superintendent of nurses of the Metropolitan General Hospital, Windsor, Ont. Educated in Toronto and Winnipeg, Miss Maybee graduated from the Winnipeg General Hospital in 1925. She has had a broadly varied experience, including two years as operating-room supervisor at the Park Hospital, Mason City, Iowa, after taking an extensive post-graduate course in that branch of nursing. Several years of experience at the Yonkers General Hospital, New York, as assistant night superintendent, operatingroom supervisor, floor supervisor, and teacher gave Miss Maybee a wealth of knowledge. In 1943, she became night superintendent at the Metropolitan General Hospital and in July, 1946, was named acting superintendent of nurses, which appointment was confirmed in December.

Miss Maybee has a deep interest in music and drama. She is a member of the Theatre Guild in Windsor. She is treasurer of the Windsor Chapter of the R.N.A.O.

Terminating a long and successful career, Helen Hulme has retired from her position as supervisor of the East End Centre of the Hamilton Department of Health, Ont. Miss Hulme received her education in the public and high schools of Hamilton, then went to the Rhode Island Hospital for her professional training. Graduating in 1910, she engaged in private duty nursing for several years in Providence, Detroit, and Hamilton.



HELEN HULME

In 1916, Miss Hulme joined the staff of the Babies Dispensary Guild in Hamilton as head of the nursing service. Through the years, the service brought well-being to large numbers of infants and preschool children. Following a survey of the health facilities in 1934, the Dispensary was amalgamated with the Department of Health and Miss Hulme assumed the position which she has recently vacated.

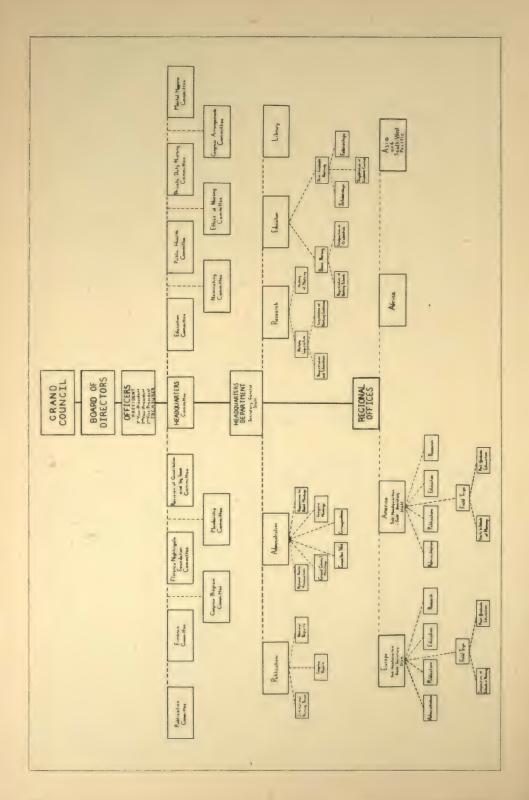
Looking back over the years, Miss Hulme feels that they were filled with joy and excitement, tears and sorrow, but most of all with learning. She has no intention of retiring from life's activities though she will no longer be in her office each day. We all wish Miss Hulme many years of good health in which to develop the variety fo pursuits she has planned.

Preview

Prenatal care has been receiving more attention in the past score of years than ever before in the world's history. A sound program of health education for the pregnant woman is recognized as being as important and logical as the health teaching of school children. We are very pleased, therefore, to be able to present an excellent article on this topic by Dr. Grantley Dick Read next month. Beth Laycraft, who served for several years at a northerly post with the Alberta Department of Public Health, will contribute a description of "Homestead"

Obstetrics." Constrasting the technique of home and hospital care, Gertrude Armstrong will describe the setting up of the case room preparatory to delivery.

How can the necessary group activity that is essential to the successful functioning of the operating-room in any hospital be achieved? How can it be made a happy and satisfying experience for student and graduate staff alike? Carol M. Adams will answer these and many other questions next month in her article on planned operating-room experience for the student nurse.



Notes from National Office

International Congress of Nurses

In addition to the information regarding the International Congress of Nurses to be held in Atlantic City, N.J., May 11 to 16, 1947, which appeared in *The Canadian Nurse*, January, 1947, page 45, a tentative program has been received and is summarized below:

Special religious services for members are being arranged for May 11. The address of welcome by the president and various speeches by outstanding personalities will be given on *Monday*, May 12, 10 a.m., followed by the president's address and various reports. In the afternoon, nursing education will be discussed under the topics: (1) Professional education. (2) Functions of professional organizations in taking care of nurses' working conditions, e.g., salaries. (3) Minimum requirements in nursing education.

Tuesday: (1) Development of industrial nursing. (2) The shortage of nurses and methods to meet it. (3) I.C.N. responsibility for international education of nurses. (4) Recent legislation as it affects nurses in Great Britain.

Wednesday: (1) An address by an outstanding scientist on the peacetime use of atomic power. (2) Newer developments in nursing education. (3) International relief work for nurses.

Thursday: (1) Post-graduate education. (2) Morale (ethics of nursing). (3) Place of the nurse in social medicine. (4) Social workers and public health nurses. (5) Professional nursing groups other than State Registered Nurses.

Friday: (1) Farewell session — introduction of new president and giving of watchword. (2) Address of new president.

Social activities: (1) Organ recital. (2) Educational moving pictures. (3) Florence Nightingale oration. (4) Dinner. (5) Excursions. (6) Entertainment. (7) Exhibits.

Diagram

The accompanying diagram (see page 302) indicates the proposed reorganization of the framework of the International Council of Nurses. Canada, as a member country, will have representation on each of the major committees. The members of each of the provincial registered nurses' associations, since they are automatically members of the Canadian Nurses' Association, are also entitled to membership in the I.C.N. There are five members from Canada on the Grand Council.

Executive Meeting

The next executive meeting, C.N.A., will be held in the Ritz Carlton Hotel, Montreal, April 28, 29, 30 inclusive. All matters relative to meetings of the I.C.N. Grand Council and Congress will be considered at this meeting.

It is with regret we announce that a registrar's conference cannot be held as planned prior to or following this executive meeting due to the International Council of Nurses Congress immediately following the executive meeting.

Labor Relations

The Board of Directors of the American Nurses' Association has voted unanimously to support the action of the National Society of Professional Engineers in calling for revision of the Wagner Act to assure professional employees "their traditional freedom of association and mutuality of action."

APRIL, 1947

In an open letter sent to the engineers, Katharine J. Densford, president, A.N.A., wrote:

The Board of Directors of the American Nurses' Association, at a meeting held on January 20, 1947, in New York City, discussed the recent action of the National Society of Professional Engineers regarding revision of the so-called "Wagner Act" to assure professional employees "their traditional freedom of association and mutuality of action."

Because we believe the action of the National Society of Professional Engineers to be most important for all professional groups, I am sending this communication to you to indicate that the American Nurses' Association wholeheartedly supports your effort to secure legislation which would clearly state that professional employees shall not be required to be members of any labor union as a condition of employment, and shall retain the right to bargain collectively if they so desire without being part of an organization not composed of professional employees only.

Since this action is most important for all professional groups, the Board of Directors of the American Nurses' Association has authorized its Committee on Federal Legislation to take immediate steps to acquaint the appropriate Congressional committees with the American Nurses' Association's support of this program.

A copy of this letter, with our recommendations, is being sent to the nurses' associations of the forty-eight states, District of Columbia, and territories, whose combined membership totals over 176,000 registered professional nurses.

This action is in line with the program adopted by the A.N.A., at the biennial nursing convention held last September. At that time, the organization stated its policy as follows:

The American Nurses' Association believes that the several state and district nurses' associations are qualified to act and should act as the exclusive agents of their respective memberships in the important fields of economic security and collective bargaining. The association commends the excellent progress already made and urges all state and district nurses' associations to push such a program vigorously and expeditiously.

Since it is the established policy of other groups, including unions, to permit membership in only one collective bargaining group, the association believes such policy to be sound for the state and district nurses' associations.

Great Britain

The Willesden incident: The secretary of the Royal College of Nursing gave a full account of the Willesden incident at a meeting held December 19. The Borough Council had issued a directive requiring all their employees to belong to a trade union, whereupon the nursing staff, of whom some 80 per cent were college members and wished to be represented by that body, had sought the advice of the college. Notices of dismissal had been served on the nurses, but they continued to maintain a strictly professional stand in very difficult circumstances. The action of the Willesden Council had provoked intense and nation-wide feeling and in view of this fact and the serious criticism of the incident made by three Ministers of the Crown, the Council subsequently withdrew their resolution.

The policy of the Royal College of Nursing, with regard to the implications of the situation, is outlined below to help nurses to a clearer grasp of the principles involved:

(1) The Royal College of Nursing holds to the principle that nurses should join an organization capable of conducting negotiations with the necessary full authority of all levels up to the national level, but that compulsion in such matters is wholly inconsistent with the status implied by membership of a professional body. This view gains the strongest possible support from the statement made by the Minister of Health, (2) While considering it desirable that all nurses should join a suitable organization it must be left to each nurse to determine for herself the particular organization which deems best suited to her professional needs. (3) Only thus can professional organizations which speak for nurses do so with the fullest measure of authority. Nurses cannot expect to receive full public recognition of

their rights as professional members unless they also are prepared in their turn to meet their responsibilities in their profession by joining an appropriate organization. The Royal College of Nursing has been given practical recognition by the Government as the pre-eminent negotiating body in the field of nursing by having alloted to it a greater number of seats on the Rushcliffe and Wheatley Committees than are alloted to any other body representing nurses. This representation is in accordance with the fact that the Royal College of Nursing has by far the largest membership of any nursing organization (comprising as it does, 54,000 general trained and student nurses). (5) The Royal College of Nursing is not, and never has desired to be, considered as a trade union, since it is a professional body constituted by Royal Charter. (6) In these circumstances the policy that the Royal College should pursue is clearly determined by the facts of the position; namely that it is: (a) the pre-eminent authority for the negotiation of all problems affecting the nursing profession; (b) recognized as such by the Government; and (c) that it can properly be regarded by members and hospital authorities alike as an authentic and competent negotiating body where all matters affecting nurses are concerned. The Royal College of Nursing does not feel itself to be in any way in competition with trade unions, of which some nurses are members. partisan attitude has been and will be avoided at all costs as calculated seriously to compromise the solidarity of nursing as a great profession and as inimical to its best interests. The Royal College of Nursing, by taking its stand upon its true status as a professional body, neither attacks nor invites attack from any. is evident from the precedents established at Willesden that this attitude on the part of the Royal College of

Nursing is effective in providing all necessary protection for the professional interests of its members.

The student nurse takes stock: The central representative council of the Student Nurses' Association, which is developing remarkable business ability, considered a wide range of resolutions at its meeting in Leicester. Subjects under discussion included: the eligibility of male student nurses for membership in the association; the allocation of the association's bursaries; the period of training in the preliminary training school; the provision of holiday homes for stu-The two resolutions dent nurses. which the association agreed to forward to Council embodied requests that ward sisters should be properly equipped to train and instruct student nurses in the wards, and that they should set aside definite times for practical teaching.

Parcels to Greece

The following is a letter received from the State School for Public Health Nurses in Athens:

The State School for Public Health Nurses was very pleasantly surprised lately by the arrival of many friendly parcels sent by Canadian nurses.

These gifts enabled almost all our 120 nurses to have a good pair of shoes and stockings, while the other effects — uniforms, dresses, etc.— were distributed to the more needy ones. We even received some very nice things for our Christmas tree.

Our intention is to thank every one separately but we want also to express through *The Canadian Nurse* our gratitude to all those who participated in the sending.

Your presents were not only a very valuable material help, but also a very friendly message that brought to Greek nurses the affection of the Canadian nurses. Both were deeply appreciated and we shall never forget them.

E. C. APOSTOLAKI,
Directress, School of Public Health Nurses

Notes du Secrétariat de l'A.I.C.

Congrès International des Infirmières

En plus des renseignements déjà parus dans The Canadian Nurse de janvier 1947, page 45, concernant le Congrès International des Infirmières à Atlantic City du 11 au 16 mai 1947, l'élaboration du programme suivant a été reçu, en voici le résumé:

Des services religieux ont êté organisés pour le 11 mai. La présidente prononcera l'adresse de bienvenue et des personnages importants feront de courtes allocutions le lundi 12 mai; à cette même séance l'on présentera divers rapports. Durant l'après-midi, la formation de l'infirmière sera le sujet à l'étude; l'on parlera (1) de l'enseignement professionnel; (2) du rôle des organisations professionnelles concernant les conditions de travail des infirmières et leur salaire; (3) des exigences scolaires, minimum pour l'étude de la profession.

Mardi: (1) Le progrès réalisé dans le nursing industriel. (2) La pénurie d'infirmières et les moyens d'y remédier. (3) De la responsabilité du Conseil International des Infirmières dans la formation de l'infirmière. (4) Des lois nouvelles en Angleterre intéressant les infirmières.

Mercredi: (1) Une conférence par un savant de renom sur les usages de l'énergie atomique en temps de paix. (2) Faits nouveaux concernant la formation de l'infirmière. (3) L'assistance internationale envers les infirmières des pays dévastés,

Jeudi: (1) Les cours post-scolaires. (2) Morale professionnelle. (3) Du rôle de l'infirmière dans la médecine sociale. (4) Les auxiliaires sociales et les infirmières hygiénistes. (5) Des personnes soignant les malades mais n'étant pas infirmières professionnelles.

Vendredi: (1) Séance d'adieu—presentation de la nouvelle présidente. Le mot d'ordre sera donné. (2) Discours de la nouvelle présidente.

Réunions sociales: (1) Récital d'orgue. (2) Cinéma éducationel. (3) Allocution sur Florence Nightingale. (4) Dîner. (5) Excursions. (6) Réceptions. (7) Exposition.

Assemblée du Comité de Régie

La prochaine assemblée du Comité de Régie de l'Association des Infirmières du Canada aura lieu à Montréal au Ritz Carlton, les 28, 29 et 30 avril. Toutes les questions concernant le Conseil International des Infirmières, le conseil supérieur, et le congrès seront considérés à cette réunion.

RELATIONS DU TRAVAIL

Le Comité de Régie de l'Association des Infirmières américaines dans un vote unanime appuie la Société Nationale des Ingénieurs Professionnels, demandant la revision de la loi Wagner afin d'assurer aux ingénieurs professionnels employés "la liberté traditionnelle de leur association et la solidarité d'action qui leur est propre."

Mlle Katharine J. Densford, présidente de l'Association des Infirmières américaines, adressa une lettre à cet effet à la Société Nationale des Ingénieurs Professionnels, en voici un extrait:

"Notre association appuie de tout coeur vos efforts pour obtenir une loi qui définira clairement qu'aucun employé professionnel ne peut être obligé de faire partie d'un syndicat pour obtenir un emploi et qu'ils doivent avoir le droit de négocier collectivement, s'ils le désirent, sans faire partie d'une organisation comprenant des membres autre que des employés professionnels."

Considérant que cette mesure est des plus importantes pour tous les groupes professionnels, l'Association des Infirmières américaines a fait savoir au gouvernement qu'elle partageait absolument les vues de la Société des Ingénieurs Professionnels sur ce point.

Des copies de cette lettre ainsi qu'une recommandation furent adressés à tous les états et districts des Etats-Unis, ce qui veut dire a plus de 176,000 infirmières professionnelles. En agissant ainsi l'A.I.A. a suivi la ligne de conduite tracée lors de l'asseptembre dernier à savoir: "L'A.I.A. croit que plusieurs associations provinciales (state and district) ont les qualifications nécessaires pour être et devraient être les seuls agents de leurs membres dans les domaines de sécurité économique, de contrats collectifs. Des progrès notables se sont réalisés à date par les associations d'état ou de district et l'A.I.A. les presse d'aller de l'avant."

LA GRANDE-BRETAGNE

A propos de l'incident de Willesden: Les journaux ont parlé avec grande manchette de

cet incident, le voici relaté par le secrétaire du Collège Royal des Infirmières:

Le conseil de la municipalité avait donné avis à tous ses employés de faire partie d'un syndicat. Les infirmières de l'hôpital municipal, dont environ 80 pour cent étaient des membres du Collège Royal des Infirmières, demandèrent ce collège comme leur agent et prirent les directives du collège. Les infirmières reçurent l'avis de leur renvoi mais n'en continuèrent pas moins à maintenir leur position de professionnelles dans des circonstances vraiment difficiles.

L'attitude du conseil de la municipalité de Willesden provoqua une vive réaction dans tout le pays, et à la suite d'une critique sévère faite par trois ministres de la Couronne, le conseil municipal retira sa résolution.

Voici les données et principes sur lesquels le Collège Royal des Infirmières s'appuie pour donner ses directives: (1) Le Collège Royal des Infirmières soutient le principe que les infirmières doivent faire partie d'une association capable de négocier avec autorité pour tout ce qui concerne les conditions de travail des infirmières aussi bien au municipal qu'au provincial comme au national, mais la contrainte dans ce domaine semble contradictoire au status que confère un corps professionnel à l'un de ses membres. La déclaration faite par le Ministre de la Santé soutient entièrement ce point de vue. (2) Bien que nous considérons comme une chose désirable que toutes les infirmières fassent partie d'une organisation, chacune doit être libre de déterminer quelle organisation convient le mieux à ses besoins professionnels. (3) Ce n'est qu'ainsi que les organisations qui représentent les infirmières et parlent en leur nom pourront le faire avec la plus grande autorité. Les infirmières ne doivent pas s'attendre à ce que le public reconnaisse leurs droits comme membres d'une profession à moins qu'elles ne soient prêtes à prendre leur part de responsabilités dans la profession en faisant partie d'une organisation convenable à leur (4) Le gouvernement a donné la preuve qu'il reconnaissait le Collège Royal des Infirmières comme agent négociateur pour ce qui concerne les infirmières, en lui accordant plus de représentants sur les comités Rushcliffe et Wheatley qu'il n'en a donné à toute autre organisation représentant les infirmières. Cette représentation était justifiée du fait que le Collège Royal des Infirmières a plus grand nombre de membres (soit 54,000 infirmières et élèves infirmières). (5) Le Collège Royal des

Infirmières n'est pas et n'a jamais désiré être considéré comme un syndicat (trade union) puisqu'il a une charge royale le constituant en corps professionnel. (6) Dans ces circonstances, la ligne de conduite que suit le collège est clairement déterminée par la position qu'il occupe de fait et dans l'opinion publique à savoir: (a) En tout premier lieu l'autorité dont il jouit comme négociateur dans tous les problèmes affectant la profession d'infirmière. (b) Il est reconnu comme tel par le gouvernement. (c) Il peut être considéré par les membres du personnel et par les autorités des hôpitaux comme un agent négociateur digne de foi et compétent dans les questions concernant les infirmières.

Le collège n'est pas en concurrence avec les unions ouvrières dont quelques infirmières font partie. Toute attitude d'esprit de partie a été et sera évité à tout prix, parce qu'il n'y a rien qui pourrait compromettre aussi sérieusement la solidarité de la profession d'infirmière et nuire à ses intérêts les plus chers.

Le Collège Royal, en prenant ses positions comme corps professionnel, n'attaque personne et ne veut être attaqué par aucun. Il est évident par l'incident de Willesden que cette ferme attitude du Collège Royal, protégeant les intérêts professionnels de ses membres, a fait ses preuves.

L'Association des Étudiantes Infirmières: Le conseil de l'Association des Étudiantes montre qu'il a de grandes aptitudes pour les affaires, si l'on considère toutes les résolutions qui ont été présentées à l'assemblée.

Les questions suivantes ont été discutées: De l'admission des étudiants infirmiers comme membres de l'association; des bourses d'études; la durée du cours préliminaire dans les écoles organisées à cette fin; des maisons de repos pour les vacances d'élèves infirmières. Les deux résolutions que l'association a accepté de présenter au conseil du Collège Royal des Infirmières sont les suivantes: Que les hospitalières soient préparées pour donner la formation et l'enseignement aux étudiantes dans les salles et qu'elles emploient une période de temps déterminée à l'enseignement pratique.

COLIS AUX INFIRMIÈRES DE GRÈCE

L'Ecole des Infirmières Hygiénistes d'Athènes remercie les infirmières du Canada qui leur ont envoyé des colis. Grâce à ces dons 120 infirmières ont pu se procurer des chaussures et des bas.

Educational Policy

Contributed by the Committee on Educational Policy of the Canadian Nurses' Association

Progress Report Demonstration School of Nursing

The Demonstration School Administration Committee is not yet in a position to announce the name of the school of nursing selected for the demonstration. However, that does not mean that this committee has been entirely inactive. Miss Nettie D. Fidler, associate professor, nursing education, University of Toronto School of Nursing, was approached by the Administration Committee and consented to carry on the necessary preliminary investigation preparatory to selecting a suitable school of nursing. Since the end of January she has visited hospital schools of nursing, interviewing the hospital administrators, superintendents of nursing, as well as meeting the governing board in certain places. The interest shown on the part of those interviewed has been most gratifying, and we are pleased to note that there have already been several inquiries from prospective students.

Unfortunately, all of the provincial nurse registration acts do not allow sufficient elasticity to ensure registration privileges to the graduates of a school such as the proposed demonstration school, which is founded on the principle that it is possible to prepare nurses adequately in less than three years in a controlled For this reason, schools of nursing in several provinces, as well as provincial registration regulations, have been investigated. It is hoped that a definite announcement as to the place which has been chosen and the name of the director can be made very shortly.

Obituaries

Mary Beard, whose sterling leadership in her chosen field of nursing has profoundly influenced developments not only in her native United States but also in Canada and the world, passed away in December, 1946. At the Memorial Service held in Grace Church, New York, on December 15, eloquent tribute was paid to Miss Beard in the address given by Dr. Allan Gregg. (This address is printed in full in the February, 1947, issue of the American Journal of Nursing.)

Miss Beard was undoubtedly one of the great women of the nursing profession. It was she who inspired the Rockefeller Foundation to contribute significantly to nursing education. The assistance given to the School of Nursing of the University of Toronto, which has meant so much to the

advancement of nursing education in Canada, was made possible through Miss Beard's efforts. Miss Beard was guest speaker at the convention of the Canadian Nurses' Association in 1936.

Mary Ann Carter, who at one time was active with the Victorian Order of Nurses, passed away in Vancouver in her eightieth year.

Georgina Henrietta Colley, who graduated from the Montreal General Hospital in 1895, died recently in Montreal in her eighty-fourth year. Following graduation, Miss Colley served on the staff at M.G.H., then engaged in social service work in surrounding areas. During World War I, she

joined the C.A.M.C. and was on the staff of military hospitals in Canada.

Isabell (Gourdier) Conley, a native of Kingston, Ont., died there recently. Mrs. Conley graduated from Watertown Mercy Hospital and practised in Newark, N.J., prior to her marriage.

Mrs. James Cook, a graduate of the Medicine Hat General Hospital, Alta., died recently in Creston, B.C., at the age of seventy-three. Though decades had passed since she engaged in active nursing, Mrs. Cook had maintained an interest in the healing art through her work on the hospital board and the Women's Auxiliary of the Creston Valley Hospital.

Alida M. Horner died recently in Duncan, B.C., after a brief illness. Miss Horner graduated from the King's Daughters Hospital, Duncan.

Flora C. Idington, a graduate of the Protestant General Hospital, Ottawa, died recently in Toronto after an illness of several weeks. Miss Idington enlisted with the C.A.M.C. early in World War I, and served in England and Scotland.

Christine Bell McRitchie, who was born in Halifax and who graduated from the Waltham (Mass.) Training School for Nurses in 1906, died on January 16, 1947. Miss McRitchie returned to Canada in 1911 and engaged in private duty in Brantford for thirteen years. After three years in Halifax, she moved to Montreal where she continued to work as a private duty nurse.

Florence (Bouck) Smyth died recently in Morrisburg, Ont. A graduate of the Kingston General Hospital, Mrs. Smyth held responsible positions in New York and other American hospitals, was on the staff of Wellesley Hospital, Toronto, and, until six years ago, was superintendent of the Bowmanville (Ont.) Hospital.

Dorothea Jean (Spratt) Welsh died recently in Cranbrook, B.C., in her thirty-fifth year. Married in 1933, Mrs. Welsh returned to active duty and served on the staff of the Kootenay Lake General Hospital, Nelson, throughout World War II.

Modern Hospital Signaling

The evolution of the modern hospital has of necessity demanded the development of numerous electrical signaling systems without which the present standard of efficiency could not be maintained. Among such systems are electric nurses' call systems, psychopathic alarm systems, silent doctors' paging systems, doctors in-and-out systems, special fire alarm systems, and special dual-motored synchronous clock systems.

The modern nurses' call system is designed to enable a patient to set up a signal which indicates by means of signal lights that a visit from the nurse is desired and also indicates the bed location from which the call originated. In this type of system, each patient's bed in private rooms and wards is equipped with a special locking push-button. When a patient depresses the centre of the locking push-button at his bed, a circuit is closed to light a numbered lamp indication at the nurses' station which shows the room

from which the call originated. A lamp is lighted in the corridor directly over the entrance to the patient's room and lamps are also lighted as required in the duty room and diet kitchens. In multiple bedrooms and wards, an additional signal lamp is usually provided at each patient's bed, so that the nurse on entering the ward can immediately determine who called. The operation of the patients' calling-button also causes mildtoned buzzers to sound momentarily at the nurses' station, at the duty room, and at diet kitchen stations which will indicate to the nurse that a call has been initiated. If a nurse should fail to respond to the patient's call, the patient may flash all above-mentioned lamps and momentarily sound all buzzers by further depressing the locking-button. Thus, this type of signaling system provides an unmistakable means of notifying the nurse of a patient's call, wherever she may be on the floor. The same nurses' calling features can

be employed to summon a nurse to any location in the hospital, such as toilets occupied by patients, solariums, and operating-rooms. The only way that the lamps may be extinguished after the patient has indicated a call is for the nurse to reset the locking push-button at the patient's bedside. Thus, the nurse is compelled to investigate the patient's call in order to cancel the signal.

Nurse-calling systems of this type can also be provided with an emergency feature so arranged that a nurse can summon assistance without leaving the patient's bedside. Such emergency systems require an additional emergency locking push-botton located adjacent to each patient's bed. When the nurse operates the emergency station, red lamps are lighted at all signal locations described for the standard system and emergency alarm bells are sounded at the nurses' stations, etc., thus directing assistance to the proper room.

Where the organization and personnel of a hospital operate per floor, it is the general practice that each floor have, in effect, its own signaling system. The plan of a hospital may necessitate calls from one floor registering on an auxiliary signaling device on another floor. In some larger institutions it is desirable to have each floor operate under its own individual system, but to have all calls also register at a central station for constant supervision of the complete hospital.

Locking button-type nurses' call systems are operated on very low voltage which provides a desirable safety factor. In addition, there are no metal parts anywhere exposed and operating current can in no way reach the patient. The present-day locking button-type calling station is designed for ease of operation, is small and compact, yet easily located by the patient. All working parts are contained in the compact locking button which may be readily replaced with no inconvenience to the patient. A suitable length of sturdy, flexible, and washable extension cord connects the button to a specially constructed plug. When plugged into the wall receptable, the patient is able to initiate a call at any time. A special feature may be incorporated into the calling-button wall receptacles whereby all signals are operated should the patient accidentally dislodge the plug from the receptacle.

Psychopathic alarm systems have been developed to provide protection for the nurse or attendant of a psychopathic patient. The installation of a system of this type

enables the nurse at any time to summon assistance. In modern psychopathic hospitals, each patient's room is equipped with a special entrance station. Psychopathic alarm systems are so arranged that an attendant, by means of a special key, operates a switch on the entrance station before entering a room and thereby lights a white lamp on a corridor station directly over the door to the room. This will signify to anyone in the corridor that an attendant has entered the room. Should the attendant require assistance when in the room, operation of a specially constructed push-button located in the room will light a green lamp in the associated corridor lamp station, light a lamp indication at the nurses' station, and will also cause alarm bells in the corridor and at the nurses' station to sound continuously. The only way that this emergency call can be cancelled is by again using the special key to turn off the switch on the entrance station. All equipment located in the rooms of psychopathic patients is of special tamper-proof construction, assembled with special tools, which makes it practically impossible for a patient to render the system inoperable. Other variations of this type of equipment are manufactured to provide various interlocking supervisory features for the protection of attendants. In some larger and more elaborate systems, additional master lock switches are provided at the entrance to each corridor or group of rooms, so that the path of an attendant may be followed.

In the majority of modern hospitals, large and small, where the visiting doctors are likely to arrive and depart at all hours of the day or night, it is important to know when a certain doctor is in or out of the building. The modern doctors' in-and-out signaling system accomplishes the desired results. A register is provided at each entrance, on which appears each doctor's name. Adjacent to each name is a switch, which when thrown to the "in" position, by the doctor on entering the building, will illuminate the doctor's name on the entrance register and on other similar registers located within view of the telephone operator, the receptionist or information desk, and various other locations as required by the plan of the hospital. A doctor on leaving the building may, by throwing his switch to the "out" position, extinguish his name on all registers. Thus, the hospital personnel can know at a glance whether or not a certain

(Concluded on Page 312)

STUDENT NURSES PAGE

An Exploratory Laparotomy

E. COUGHLIN

Student Nurse

School of Nursing, Regina General Hospital, Saskatchewan

MRS. T had had a cholecystectomy in 1933 and had never been really well since. Recently, she became so ill that it was necessary to bring her to the hospital. Her symptoms at this time were jaundice, nausea and vomiting, excruciating pain in the gallbladder region with occasional severe chills. Laboratory tests showed bile in the urine, a high white blood, rhodocyte and lymphocyte count, showing pronounced infection. The icterus index was high also which indicated liver impairment.

Our patient was very ill for several days and, as she vomited everything taken by mouth, was given fluids and nourishment in the form of intravenous glucose 5% on normal saline. Penicillin therapy was also commenced. For a time she was very listless, nervous, and unable to sleep but gradually began to improve and was ready for operation. This consisted of an exploration of the common bile duct. Adhesions between the liver and surrounding tissues had to be separated. It was found that there were two perforations — one in the common duct and one in the duodenum so that bile, pus, and fecal matter, as well as small stones, were escaping into the peritoneum. hepatic ducts and common duct were washed out by means of a catheter and twenty-five grevish-brown and

golden-yellow stones were removed. There was also an abscess in the duodenum which had to be cleaned away. A T-tube was inserted with difficulty. The duodenum was closed with two layers of sutures after which part of the omentum was sutured in place over the suture line of the duodenum. Two cigarette drains were placed in the wound and the incision closed.

On return to the ward, Mrs. T's blood pressure fell quite rapidly and during the day it was necessary to administer neo-synephrine four times. No drainage came through the T-tube but a large amount of dark green substance oozed from around the tube, making it necessary to change the dressing frequently. She was given 5% and 10% glucose in normal saline intravenously almost continuously,

On the fourth day, a large amount of watery-green drainage, showing fecal matter, appeared on the dressing. An attempt was made to pass a Miller-Abbott tube into the duodenum beyond the sutured area but x-ray showed the tube to be curled in the stomach. When it was removed, there was a knot in it. A Rehfuss tube was then inserted with difficulty. This tube has a metal tip with large openings through which the the patient can be fed.

Healing appeared to be very slow. The doctor ordered amino acids to be

VPRH . 1947

added to the intravenous injections. These are a substitute protein feeding when the patient is unable to eat sufficient protein to supply the body's needs. Enough must be given to meet the protein requirements of the body plus an additional amount to correct deficiencies. Carbohydrates must also be given to meet the caloric needs of the body. Mrs. T was given glucose intravenously to supply the calories needed. Each day for five days she was given 2000 cc. 5% glucose in normal saline containing 400 cc. of amino acids.

The wound continued to drain bile and fecal matter and at times gas appeared to be bubbling from the incision. To encourage healing 20 cc. of blood was taken from her arm and injected into the wound to form This seemed to help very a clot. little. Three more similar injections were made on consecutive days using the blood of a healthy donor and the wound began to heal gradually until there was no fecal matter and only The tissue a scant amount of bile. drains were removed at the end of a week and two days later the T-tube was removed. The following day the sutures were taken out. There had been some sloughing and the wound had to be cauterized.

While the Rehfuss tube was in, a special duodenal feeding was used consisting of 18% cream, whole milk, orange juice, eggs, brewers' veast powder, liver extract, and vitavose. The total number of calories given in a day was three thousand. This feeding contained vitamins A, B₁, B₂, C, D and 21 mg. of iron. There was more than the normal daily requirement of vitamins, except vitamin D and she was given Oil of Percomorph gtt. xx daily to supplement the vitamin D in the feeding. She was given this feeding every two hours as follows: 25 cc. of water, followed by four ounces of the feeding, followed by another 25 cc. of water. Later she was fed two ounces every hour in a similar manner. The tube was removed after eighteen days. Then Mrs. T began eating soups and other liquids until her diet had been increased gradually to a soft bland diet.

Her condition improved daily once the healing processes began and within four weeks she was allowed out of bed. Her strength returned slowly but surely and a week later she was discharged from the hospital in a satisfactory condition. The doctor stated that her recovery had been assisted to a very considerable extent by the nursing care which she had received.

Modern Hospital Signaling

(Continued from Page 310)

doctor is in the building. An additional feature that may be incorporated in doctors' in-and-out systems provides a flashing feature. If the receptionist or telephone operator should have a message for a particular doctor, she may operate a key on a special keyboard so that when the doctor enters the building and throws his switch to the "in" position, his name will flash instead of being steadily illuminated. This flashing lamp will indicate to the doctor that he is to report for a message. This same arrangement is also sometimes extended to be used for silent paging of the doctors in the building. In such cases, duplicate registers with all doctors' names are provided at each nurses' station on each

floor or section. Should the nurse on duty notice a doctor's name flashing, she can inform the doctor that he is wanted.

Several types of signaling systems are used expressly for the purpose of silently paging the doctors and other hospital personnel. The type and design of the system will mainly depend on the number of people involved and the size of the hospital. The majority of these systems all operate on the same principle. Each person to be paged is assigned a number. A sufficient quantity of numbered lamp annunciators are located throughout the hospital corridors and rooms, so as to be readily visible. When it is desired to page a certain doctor, the operator may press the proper key on a keyboard and light the

numbered lamp associated with the doctor's name on each annunciator. In large hospitals where it is often required to page a number of doctors at one time, similar systems are manufactured which will flash the doctors' code numbers alternately on all annunciators.

Special centrally controlled dual-motored clock systems are now available. Such systems are made up of the required number of dual-motored synchronous clocks and either a manual or automatic resetting device. Once all clocks in the system are set at the same time and started, they will all keep in synchronism. If the power supply to the system should fail for a period of time, on restoration of power all clocks of the system will be automatically advanced to the correct time if an automatic reset control is used. If a manual reset control is used, the resetting can be controlled manually. Such clock systems can also include program instruments which can be set up to sound signals on any predetermined schedule.

Special local fire alarm systems have been developed for hospital installations. The intent of such systems is not to alarm the patients in the event that a fire alarm signal is transmitted, but to indicate to all personnel

the location of the fire alarm box from which the alarm was transmitted.

The electrical signaling industry now has available, as standard production items, a complete line of equipment to cover all the signaling requirements of the modern hospital. All hospital signaling equipment has been designed to be rugged, compact, and to harmonize with the architecture and appointments of the modern hospital.

Preview

In order to give each nurse a clear picture of the goals in invalid feeding, H. Jean Leeson continues our series of articles on nutrition with "Optimal Nutrition for Patients." Dr. Leeson says, "It is the nurse's responsibility to look after patients' nutrition, because ultimately she is the only one who can make sure that the patient actually consumes the proper amount and the kinds of food prescribed by the physician." Her account of the role food plays in the healing of wounds and injuries, in acute febrile cases, etc., will make valuable reference material.

Book Reviews

Teaching in Schools of Nursing, Principles and Methods, by Loretta E. Heidgerken, R.N., M.S. 478 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25, 1946, Price \$4.50.

Reviewed by Marion Lindeburgh, Director, McGill School for Graduate Nurses, Montreal.

The author of this book has been a successful teacher of the nursing arts in undergraduate schools of nursing, and for several years has been engaged in the development of advanced nursing education programs; the breadth and richness of her professional experience are reflected throughout her book. The author's familiarity with school of nursing curricula, and with effective methods of teaching, serve her high purpose to share with teachers of nursing some fundamental principles of learning and teaching in making the experience of student nurses a purposeful,

challenging, enjoyable, and progressive educational process.

The particular merit of this book is in the fact that the author aims to deal mainly with the psychological factors affecting learning, and the interpretation of teaching as a function which motivates students, and guides them in their learning activities toward desired goals. In other words, the book does not contain subject matter of nursing courses, which can be found in approved curricula, but rather with the why and how of making the nursing program more effective in promoting the professional growth of students.

A brief reference to the content of the book might be of value in illustrating the author's purpose. Possibly the greatest weakness in the teaching of nursing is the lack of a philosophy underlying nursing education, and of aims of teaching. The author has not failed in her introduction to emphasize the democratic ideal, and the aims of nursing education, all of which should be most helpful to teachers of nursing.

Under the caption of "Learning Activities," the author deals fully with the essentials of purposeful learning which must be promoted through effective teaching. Particular stress is placed upon the development of interests and motives towards desirable thought and action. The book includes a full discussion on "Planning" as a means whereby students may accomplish the most in understanding, skills, ideals, and appreciations within a prescribed period of time. Another section is devoted to recognized methods of teaching in which the author attempts to evaluate teaching techniques in relation to lecture, discussion, conference, seminar, panel, nursing care studies, etc.

In recent years increasing emphasis is placed upon the learning value of visual aids, and the author gives many helpful suggestions in the use of graphs, charts, educational films, and of various other types of illustrative teaching tools.

The last section of the book deals with "Evaluation" as applied to the teacher, the student, and the program. Various tests, now in use, are discussed and evaluated.

The reader cannot fail to recognize the author's understanding of educational psychology in the planning of a guidance program, and her ability, through long experience, to cite and apply the principles of learning to the science and art of teaching.

Gynecology for Nurses, by Archibald D. Campbell, M.D.C.M. and Mabel A. Shannon, R.N. 274 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 1946. Price \$4.00. Reviewed by Irene Cooper, Clinical Instructor, Obstetrical Department, Winnipeg General Hospital.

In this book for nurses the authors have endeavored to "bridge the gap between general nursing and gynecology" by providing a guide for nursing the gynecological patient.

The first section of the book, which deals with anatomy, physiology, and endocrinology, is exceptionally well done. Other topics are normal and abnormal pregnancy, diseases and disorders of the female organs.

Numerous illustrations, including excellent

colored plates, clarify the discussion of the various conditions and treatments.

An interesting innovation to the book is a discussion of the nurse's duties in the gynecologist's office, which may also be applied to the nursing practice in the hospital clinic. The last section deals with the care of the hospital patient and includes clear, concise procedure outlines which could readily be adapted to the various ward situations. A complete outline and vocabulary accompanies each chapter.

To be used as a text, certain readjustment may be necessary to meet the individual views of instructors and ward situations. It should, nonetheless, find a place in all gynecological departments. It will be of especial interest to Canadian nurses, since both the authors are Canadians.

Eye, Ear, Nose and Throat Manual for Nurses, by Roy H. Parkinson, M.D. 247 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: Mc-Ainsh & Co. Ltd., 388 Yonge St., Toronto 1. 5th Ed. 1946. Illustrated. Price \$2.75. Reviewed by Elsie Denman, Supervisor, Eye, Ear, Nose and Throat Department, Montreal General Hospital.

Dr. Roy H. Parkinson in his fifth edition of "Eye, Ear, Nose and Throat Manual for Nurses" has given us a textbook truly for nurses, particularly student nurses.

The chapters on throat, nose and ear, covering anatomy and physiology, as well as the diseases occurring in these areas, are concise and free from technical terms. The accompanying illustrations should be of much value in helping the student in her study of this subject.

The section on "Eye" gives us many definitions of terms commonly used, yet which seem so difficult for nurses to master. The anatomy and physiology of the eye is covered sufficiently and well enough to impress upon the nurse the importance of very careful management of the treatment of this delicate organ. Some of the more common diseases are also dealt with here.

Part II is concerned with operating-room techniques with accompanying illustrations. Part III deals with problems met by the public health nurse.

This manual covers those points which are most essential in nursing in eye, ear, nose and throat, and is well worth possessing.

Assistant Superintendent. State qualifications and salary expected. General Duty Nurses. 6-day week. Hospitalization Plan. Salary: \$100 per month with full maintenance. Apply to Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

Instructor. Ward Head Nurses. General Staff Nurses. Applications are invited from nurses eligible for licensing in the Province of Quebec. In first letter state date of graduation, qualifications, experience, and when services would be available. Apply to Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

Registered Nurses for General Duty at the Toronto Hospital for the Treatment of Tuberculosis, near Weston, Ontario. 8-hour day and 6-day week. Gross salary (straight 8 hours): \$150 per month for the 1st year; \$155 the 2nd year; \$160 the 3rd. For broken hours: \$155 per month for the first year; \$160 the 2nd year; \$165 the 3rd. One day's sick leave with pay per month, accumulative. 3 weeks' vacation per year, with pay. Generous Pension Plan. Apply to Supt. of Nurses.

Provincial District Nurses in the Province of Alberta. Districts located in rural areas. Cottage, water, and fuel supplied by community. Salary: Minimum of \$1,500 per annum, plus Cost of Living Bonus. Sick leave. Annual vacation provided after 1 year's service. For further information apply to Miss Jean S. Clark, Director, Division of Public Health Nursing, 218 Administration Bldg., Edmonton, Alta.

New Brunswick Division, Canadian Red Cross Society, is prepared to expand its Outpost Hospital and Nursing Service when nurses are available. Openings for: (1) Visiting Nurses for outlying districts. Public Health course desirable but not essential. (2) Hospital Nurses for two 10-bed hospitals to be opened during next few months. Staff of each to consist of Superintendent and 3 General Staff Nurses (with domestic staff in addition). (3) Positions available immediately for additional nurse on staff of hospital now in operation, and for vacation relief. For further information apply to New Brunswick Division, Canadian Red Cross Society, 66 Prince William St., Saint John, N.B.

Classroom Instructress for 100-bed hospital. Apply, stating qualifications and when services available, to Supt. of Nurses, Sherbrooke Hospital, Sherbrooke, P.Q.

Operating-Room Nurses, Obstetrical Supervisors and Night Supervisors with knowledge of Obstetrics. Full maintenance; good living conditions. 470-bed hospital. Apply to Supt. of Nurses, General Hospital, Saint John, N.B.

Registered, Graduate Nurses for General Duty at once in a modern 35-bed Municipal Hospital in a thriving community. Salary: \$100 per month with full maintenance. 8-hour day and 6-day week. 3 weeks' holiday with pay and raise in salary after a year of service. For further particulars apply to Matron, Municipal Hospital, Taber, Alta.

Registered Nurses (2) for Community Hospital where excellent salaries are paid. Living accommodation provided. For particulars write to Dr. H. R. Clouston, Supt., County Hospital, Huntingdon, P.Q.

Clinical Teaching Supervisor and Assistant Night Supervisor. Full maintenance provided. State experience and salary expected. General Duty Nurses. Full maintenance. 8-hour day and 6-day week. 1 month vacation per year. Apply to Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Obstetrical Supervisor for 40-bed Obstetrical Dept. Post-graduate experience necessary. 8-hour day and 6-day week. 4 weeks' vacation with pay after a year's service. 11-days' sick leave per month accumulative up to 3 weeks yearly with free hospital care after 3 months' service. Apply, stating qualifications, experience, and salary expected, to Director of Nurses, General Hospital, Kingston, Ont.

Supervisor of Home Nursing Classes, qualified to later assume direction of Red Cross Home Nursing and Reserve Dept. Applications are invited from Graduate Nurses with Public Health training or experience and executive ability. Apply to Chairman, Home Nursing Dept., Hamilton Branch, Canadian Red Cross Society.

Nearly 3 per cent of the young people growing up in Canada today become university graduates. Women constitute about one-fourth of this number. A few women

appear in the record of every branch of study but they have held mainly to Arts, including Science and Commerce, and to Education, Social Service, and Public Health.

Official Directory

THE CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Committee on Institutional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing.

Alberta: (1) Miss B. A. Beattie, Provincial Mental Hospital, Ponoka; (2) Miss A. M. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss E. I. Stewart, Ste. 2, 10625-111th St., Edmonton. (4) Mrs. B. Kipp, 807-14th St. S., Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5, 1334 Nicola St., Vancouver.

Manitoba: (1) Miss B. Seeman, Winnipeg General Hospital; (2) Mrs. H. Copeland, Misericordia Hospital, Winnipeg; (3) Miss D. Dick, 145 Montrose St., Winnipeg; (4) Miss Jean McPhail, 859 Bannatyne Ave., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospital. Saint John; (3) Miss Lois Smith, Walker Apts., York St., Fredericton; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton.

Nova Scotia: (1) Miss L. Grady, Halifax Infirmary; (2) Sr. M. Beatrice, Glace Bay; (3) Miss M. Shore, V.O.N., Halifax; (4) Miss M. Stevens, Box 345, Amherst.

Ontario: (1) Miss N. D. Fidler, School of Nursing, University of Toronto, Toronto 5; (2) Miss E. Young, Ottawa Civic Hospital: (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs, Toronto 2; (4) Miss K. Layton, 341 Sherbourne St., Toronto 2.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. Mary Irene, Charlottetown Hospital; (3) Miss E. Wheler, Summerside; (4) Miss M. Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25; (3) Miss A. Girard, l'Ecole d'Infirmières Hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 2c, (4) Miss E. Killins, 3533 University St., Montreal 2.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss N. Lambert, 341-12th St. W., Prince Albert; (3) Miss E. Smith, Dept. of Public Health, Regina; (4) Miss M. R. Chisholm, 805-7th Ave. N., Saskatoon.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q. Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans Affairs, Ottawa, Ont. Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man. Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta. Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont. Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

EXECUTIVE OFFICERS

International Council of Nurses: 1819 Broadway, New York City 23, U.S.A. Executive Secretary, Miss Anna Schwarzenberg.

Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. General Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses: Miss E. Bell Rogers, St. Stephen's College, Edmonton.
Registered Nurses' Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
Manitoba Ass'n of Registered Nurses: Miss Laura Fair, 214 Balmoral St., Winnipeg.
New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.
Registered Nurses' Ass'n of Nova Scotia: Miss Nancy Watson, 301 Barrington St., Halifax.
Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.
Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlotte-town.

Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25, Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 103 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

VOLUME 43 NUMBER MONTREAL MAY 1947

GANADIAN NURSE



Health Education of the Pregnant Woman by Dr. G. D. Read

Optimal Nutrition for Patients

by Dr. H. J. Leeson



Air Ambulance Service Creu



No at a sat I ilm B art Pat



had on duty, the Government would probably have a brand new class of capitalists to tax. Every nurse, however, realizes that it pays big dividends to obtain rapid symptomatic relief by the use of a tested and effective analgesic.

preparation. Its formula has won virtually universal approval for its effective analgesic action, while the purity of its ingredients and careful compounding ensure a rapid, dependable

effect. For a trial sample, simply tear out and mail the sample offer below.

Each product contains

'EMPIRIN' (Brand of Acetylsalicylic Acid) gr. 3½
PHENACETIN
CAFFEINE
gr. ½
gr. ½

TABLO D'BRAND
TRADE
MARK

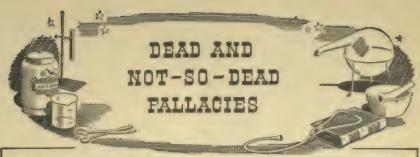
Please send me without obligation a sample issue of 'Tabloid' Brand 'Empirin' Compound.

M M M M M M M TO THE

Name

Address







During Colonial times, a Dr. Perkins patented an appliance which was supposed to cure disease.

It consisted of two short metallic rods, suggestive of electric current, that were drawn over the skin.



Rust on the outside of a can is no indication that the food inside is contaminated.

Unless the rust has pierced the metal, the contents are perfectly safe and nutritious.



AMERICAN MONTREAL HAMILTON

CAN TORONTO

COMPANY VANCOUVER

at it . Out

329

Now available on request—	
"THE CANNED FOOD	
REFERENCE MANUAL"	

-a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

CANNED FOOD IS GRAND FOOD

7 1	AMERICAN CO	
	Please send me	the res Car
	REFERENCE 3	JANUAL, wh
1	Nume	
/	Pr fessional Title	
4	Address	
		Y

MAY, 1947

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR MAY, 1947

An Equation	343
HEALTH EDUCATION OF THE PREGNANT WOMAN	345
DELÍVERY ROOM TECHNIQUE	349
HOMESTEAD OBSTETRICS	352
CARE OF THE UNMARRIED MOTHER AND CHILD N. W. Philpott, M.D. and C. F. Goodwin	357
OPTIMAL NUTRITION FOR PATIENTS	360
UP IN THE AIR WITH PATIENTS	363
Cost Analysis of a School of Nursing	367
PLANNED OPERATING-ROOM EXPERIENCE FOR THE STUDENT NURSE C. M. Adams	370
L'Aide ou Auxiliaire en Manitoba	373
Interesting People	376
CARDEX SYSTEM FOR NURSES' ORDERS	379
Notes from National Office	381
Notes du Secrétariat de l'A.I.C	384
Toward a Better Understanding	387
Hernia in Infants	389
Book Reviews	390
News Norge	400

Subscription Rate: \$2.00 per year — \$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.O.



DRAX means less washing.. easier washing..at lower cost!

Imagine! One product that can do all this! Protect washable fabrics from dirt, soil and water—thus keeping them clean and fresh-looking longer...make them easier to wash—because dirt does not get ground in to the fabric, rinses quickly away.

All this means cutting down on the size and the cost of your laundry.

And all this DRAX does! DRAX, made by the makers of Johnson's Wax, is actually an invisible, inexpensive rinse that gives uniforms, bedspreads, tablecloths, curtains, the wonderful protection of wax.

They stay clean longer . . . they wash clean easier. You'll find it will pay you dividends to find out about DRAX right now!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

MAY. 1947

Reader's Guide

After ten years of tethered activity, the International Council of Nurses has convened this month in Atlantic City, N.J. The general secretary of the Canadian Nurses' Association, Gertrude M. Hall, has been an active participant in all of the deliberations. She has promised to provide the readers of the Journal with a full word picture of the happenings, written in her own inimitable style. We hope that we shall be able to feature this material in an early summer issue.

The dominant note this month stresses various aspects of the maternity cycle. Adequate prenatal care is one of the products of the twentieth century. Its importance has been proven on countless occasions. Despite the establishment of clinics in out-patient departments, increased supervision by physicians, and a broader instruction by nurses. much still can be accomplished in reaching the expectant mothers early in their pregnancy. Grantley Dick Read, M.A., M.D., is a leader in this field in Britain. Through the courtesy of the League of Red Cross Societies we are able to present his very logical and useful program of health education for the pregnant woman.

Gertrude Armstrong, who is supervisor of the operating and delivery rooms at the Royal Victoria Montreal Maternity Hospital, has described in detail the steps that are taken following the admission of a patient. The technique used in the labor and case rooms is a sound model that any hospital might follow. Special mention should be made of the excellent photographs by Hayden, F.R.P.S., which illustrate the set-up and equipment.

Not all deliveries occur in hospital. In northern Alberta, miles from the nearest doctor, the specially prepared district nurses conduct the confinements with skill and precision. Beth Laycraft has given us a detailed description of this phase of their work.

To round out this series of articles, we present an able discussion of the problems the unmarried mother faces, the decisions she has to make, and how help can be given to her. This article, by N. W. Philpott, M.D. and Christina F. Goodwin, is reprinted

with the kind permission of the Canadian Medical Association Journal.

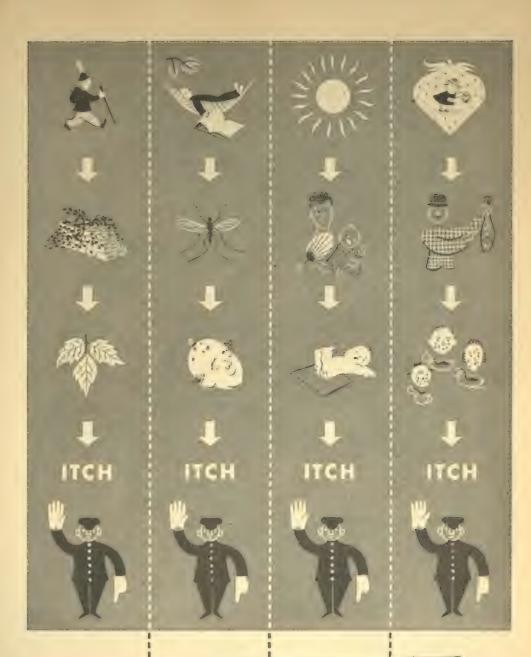
Dr. H. Jean Leeson has sound advice for nurses in connection with the value of nutrition in the healing of wounds and fractures, in chronic diseases, etc. Did it ever occur to you that when a patient is on a liquid diet or when the physician orders "force fluids" that the salt content of the blood will be sharply reduced unless special precautions are taken? This article will be most useful to every nurse for reference purposes.

Mrs. M. E. Gleadow is a member of the Air Ambulance Service crew pictured on our cover this issue. Hers is a fascinating and vigorous life. Elva Honey and Louise Bartsch are completing their work this year for their degrees in nursing at the McGill School for Graduate Nurses. Carol M. Adams is doing post-graduate work in New York.

Isabel Richardson and Catherine Mac-Leod are head nurses at the Saint John General Hospital, N.B., where the described Cardex system has been saving nurses' time and energy for over two years.

Frances Waugh has been charged with the responsibility of administering the Practical Nurse Act in Manitoba since its inception. She delivered this address to a meeting in Montreal. It is translated here for the information of the French-speaking nurses of Canada.

As a means of stimulating increased subscriptions to *The Canadian Nurse*, it is planned to give the figures of the distribution by provinces here each month. The paid circulation in Canada for April was: Alberta 826, British Columbia 1,168, Manitoba 409, New Brunswick 583, Nova Scotia 502, Ontario 3,289, Prince Edward Island 100, Quebec 1,064, Saskatchewan 590. Watch for your province. Help the total to grow!



CALMITOL

The Learning Miles Co. Ltd.
I NOTRE DAME ST. W., MONTREAL I, CANADA

MAY, 1947



AYERST BRAND OF CALCIUM PENICILLIN

100,000 I.U. PER TABLET (No. 853)

50,000 I.U. PER TABLET (No. 852)

25,000 I.U. PER TABLET (No. 851)

ALL STRENGTHS ARE SUPPLIED IN VIALS OF 12 TABLETS

AYERST, MCKENNA & HARRISON LIMITED

Biological and Pharmaceutical Chemists

MONTREAL

CANADA



"Winter taught me about the little blue jar"

student nurse I learned what scores of nurses have known for years—to use the Medicated Skin Cream NOXZEMA for rough, red chapped hands, as well as unattractive skin blemishes, tired, burning feet, and other common skin discomforts.

Later I found greaseless, stainless NOXZEMA was an effective night cream, that it made my skin feel so much smoother, softer.

Now I use NOXZEMA also as a cream to help soften, whiten my rough, red hands and of course I love it as a regular base for makeup. To me, it's a "whole beauty course" in a little blue jar!..

MAY, 1947

They look to you, Doctor..

"The destruction of bacteria (disinfection) or interference with

their activities (antisepsis) by chemical means is attempted daily in

proceedings ranging between proved usefulness and utter futility."

Garrod, L.P. and Keynes, Geoffrey L. (1937) Brit. Med. J. 2, 1233.

I should have been addressed to the medical profession itself, how much more does the unskilled user of antiseptics—the ordinary householder—stand in need of guidance!

ALL ANTIBACTERIAL agents — whether for treatment or prevention — are in some degree selective. The choice of the antibiotic or chemotherapeutic substance for treating an established infection is a matter for your skill. But the choice of the antiseptic for preventive use in the home is a matter which calls clearly for your advice.

FOR GENERAL USE in unskilled hands, obviously the less selective agent is to be preferred.

Now, it is one of the many advantages of 'Dettol' that it is rapidly lethal to a diversity of common pathogenic organisms; to haemolytic streptococci, to Strep.pyogenes, Staph.aureus, B.coli,

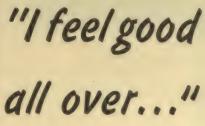
RECKITT & COLMAN (CANADA) LIMITED

B.typhosum and to such wound contaminants as B.proteus and Ps.-pyocyanea. And for all this low selectivity, 'Dettol' is non-toxic, highly bactericidal in the presence of blood, pus and other wound debris, pleasant in smell and non-staining to linen or the skin.

its High germicidal efficiency, safety and pleasantness have won preference for 'Dettol' in all the leading maternity hospitals of Canada. The value of such a non-poisonous antiseptic for prompt unsupervised use in households (where there may be young children) needs no emphasis.

'DETTOL' OBSTETRIC CREAM is a preparation of 30 per cent. 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against reinfection by haemolytic streptococci.

PHARMACEUTICAL DIVISION, MONTREAL





"... since you advised mother to care for

my tender skin with gentle Baby's Own Toiletries."

Baby's Own Soap, Oil and Powder contain
only pure, carefully-tested ingredients. Expert
dermatologists have pronounced them ideal
for babies' delicate skin. And 75 years experience
and research in making baby toiletries
stand behind every product.

You may recommend Baby's Own Toiletries with confidence, for even the most sensitive skin.



The J. B. WILLIAMS CO. (CANADA) LIMITED

La Salle, Montreal

Penioral

Penioral (Buffered Penicillin Wyeth) reaches the patient Laboratory-Fresh. It is protected three ways against moisture, arch enemy of penicillin.



- · Vial is sealed air-tight until opening.
- · Desiccant absorbs moisture after vial is opened.
- Blue indicator turns pink when excessive moisture threatens full potency of the penicillin.
- · Added protection-expiration date on every vial.

Each vial contains an average day's prescription

25,000 International Unit tablets—Vials of 12

50,000 International Unit tablets — Vials of 8

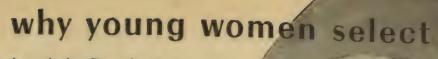
100,000 International Unit tablets — Vials of 8 For assured
Potency —
Write PENIORAL
on your
Penicillin R



Registered Trade Mark







TAMPAX

Fortunate indeed is the young girl of today who learns about the TAMPAX method of intravaginal protection almost from the time of her first menses. She will enjoy greater freedom, safety, comfort and daintiness 1,2,3,4 throughout her periods, and need never experience the drawbacks of older methods of protection.

In several large cities, for instance, every high school girl was recently taught the TAMPAX method of hygiene—and in literally hundreds of leading schools and colleges TAMPAX is recommended in physical education and home economics courses. In many units of the youth clubs also, instructions are freely given in the TAMPAX technique.

The Junior absorbency of TAMPAX (easily introduced without apertural strain) is usually favored by younger women—though Regular and Super absorbencies are also available. May we send professional samples?

RESERVATE.

REFERENCES: (1) West. J. Surg. Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943; (4) Am. J. Obst. & Gyn., 48:510, 1944.

TAMPAX

PROY.

Canadian Tampax Corporation Ltd., Brampton, Ontario.

Send literature and professional samples.

Quote prices on TAMPAX for office use

NAMI a (Please print)

ADDRESS

FV 13

Accepted for Advertising by the Journal of the American Medical Association

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to:

Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. O.

or

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

QUEEN'S UNIVERSITY SCHOOL OF NURSING

COURSES OFFERED

- Degree Course leading to B.N.Sc. Opportunity is provided for specialization in final year.
- 2. Diploma Courses:
 - (a) Teaching, Supervision in Schools of Nursing.
 - (b) Public Health Nursing.

For information apply to:

DIRECTOR SCHOOL OF NURSING

QUEEN'S UNIVERSITY KINGSTON, ONTARIO

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses -

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

000

-One-Year Certificate Courses-

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses 1266 Pine Ave. W.

McGILL UNIVERSITY, MONTREAL 25

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.



Into every tin of Nestlé's Evaporated Milk goes the skill gained in eighty years' experience in making infant diet foods all over the World.

Nestlé's Milk Products
(Canada) Limited
METROPOLITAN BUILDING, TORONTO



MAY, 1947

Nutritional Data for Professional Use

A list of charts, booklets, publications, etc., especially prepared for and distributed gratis to physicians, dentists, nutritionists, dieticians, educationalists, nurses and others, and supervised by the

Heinz Nutritional Research Division

Inquiries will be welcomed for the following material which is in good supply at the present time:

- NUTRITIONAL CHART, 12th Revised Edition, a 48-page book concerning vitamins, minerals, enzymes, allergies, etc.
- NUTRITIONAL OBSERVATORY, a publication issued 4 times yearly, which supplements the above.
- A GUIDE TO BETTER NUTRITION (wall chart or loose leaf).
- FOOD CALORIC CONTENT CHART.
- THE NUTRITIVE VALUE OF VEGETABLES (booklet).
- THE STORY OF FOOD PRESERVATION, a 96-page illustrated brochure.
- Physician's File Card on Strained Foods.

Address requests to

H. J. HEINZ COMPANY OF CANADA LTD.

420 - 430 Dupont Street, Toronto 4, Ontario

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER FIVE

MONTREAL, MAY, 1947

encinement continue c

An Equation

May, 1947, will go down in nursing history as the month when the nurses of the world reconvened for the first time in ten years to think and plan together, to co-ordinate nursing activities, to do their part in building a better world.

Planning for the future is excellent. But there are urgent needs today which are being tackled with skill by a few but which need the co-operation of all if the problems are to be solved. Outstanding among these is the obligation to inform the public—the men and women whom we serve as patients as well as all of their 'friends and relations,' the ominous group known as the rate-payers—regarding the difficulties and achievements of the nursing profession.

Today, on every side, we hear comments and criticisms related to the so-called shortage of nurses. As the first plank in our platform of public relations let us place the emphasis where it rightly belongs. There are more nurses in Canada today than ever before in our country's

history. It is the demand for nursing service which has leapt to unpre-

cedented heights.

There is an acute demand for a great many products and services today. There is an enormous demand for houses, for offices, for teachers, for nurses, for mechanics, for stenographers, for house maids, for gardeners. This excess of demand over supply is evidenced in the waitinglists for automobiles, the queues that still form for scarce commodities, the reservations for hotels as well as for hospital accommodation. These are all parts of the same picture. To single out any one part as being more important or more acute is to overlook the significance of world events. These demands were created by and are a direct result of the years of war and altered living conditions. The use of superlatives or of potent vocabulary has heightened the problem in many respects. We hear of "grim crises," "exploitation," "dire results," etc. All the forebodings of calamity are there and yet, so far as nursing is concerned, the steadying

MAY, 1947

discipline which is inherent in our training is maintaining our response to professional demands on a relatively

high level of performance.

The first requisite in any public relations program is a fully informed personnel who will carry on the education. During the war years, a broad publicity program was carried on from provincial as well as our National Office. There, news releases, radio information, booklets, pamphlets, addresses by the hundreds were presented to an interested public. One secretary spent almost her full time in making thousands of community contacts. This concentrated activity terminated with the cessation of the Federal Grant. On a smaller scale, publicity is still being carried on through the national and provincial offices but these efforts are not enough. Every nurse in Canada has the responsibility today to inform her immediate circle of the public about the positive side of nursing.

At this point, the average reader of this editorial may have one of two reactions. She will be bored and stop reading. She will be mildly indignant at the suggestion that she should "inflict" the problems of nursing on an already overburdened public. Both responses are wrong. They are indications that either she does not know what is going on, the head-hiding in the sand response, or that, being aware, she chooses to ignore her re-

sponsibilities.

No salesman can make a success of his undertaking if he does not believe firmly in the value of his product. To promote his knowledge and belief, his firm sees that he is thoroughly familiar with what the product may be expected to accomplish, wherein it excels similar products, how it can be made to appeal to the widest public, etc. In other words. he receives instruction in how to sell his product most successfully. Nurses know their product—nursing service. They have spent three years learning the various aspects of it. Unfortunately, many of the best nurses do not know how to inform the public about their work and their responsibilities. Nurses need this form of education, too. When each one of us knows and believes in the quality of service that nurses have to offer, our concerted voices will result in the long sought improvement of hours of work, salaries, living conditions, etc. The demand for nursing service is high but the. understanding of its concomitant factors is low. Only by every nurse acting as an interpreter to the public, both in her professional services and her comments to those around her, will the desired objectives of public relations be achieved.

Nursing skills + education of the public = understanding + support. A problem of simple addition if the essential components are there! A never-to-be-solved problem of higher mathematics if either element is lacking! All of the other factors, such as the use of subsidiary nursing groups, adjustments in hours of work, salaries, etc., will fall into their rightful place if and when the nurses are ready and willing to supply the balancing integers. — M.E.K.

Preview

In his second article on new methods of treatment for venereal disease, Dr. B. D. B. Layton discusses what is being accomplished in the control of gonorrhea. Though it is much less common than it was a quarter of a century ago, 2.4 per cent of all blindness is still due to ophthalmia neonatorum. In spite of the routine instillation of silver nitrate into the infants' eyes at birth cases of infection still occur. To be absolutely safe from the blinding danger of gonococcus, gonorrhea

itself must be eliminated. From information available it would appear that the use of penicillin as an effective treatment seems well established.

"A good diet may add not only years to one's life but life to one's years." With this introductory sentence, Mrs. H. Ruth Crawford opens her second valuable article in the series on nutrition. Next month Mrs. Crawford will discuss some of the problems of meal planning and preparation.

Health Education of the Pregnant Woman

GRANTLEY DICK READ, M.A., M.D.

N THE MID-VICTORIAN era it was not difficult to have large families and to bring them up in a relatively satisfactory manner, but it is extremely difficult today and, unfortunately, although childbearing is the most important of all human functions, the mother herself has. until recently, received little attention that might make her task easier. Further, pain in childbirth has been accepted as inevitable. Obstetric teaching has made great advances in the use of drugs, analgesics, and anesthetics, but little has been done to investigate the problem of pain from the point of view of its pre-The use of pain-relieving devices has been so limited that they are available to only relatively few women, and this fact has undoubtedly created a fear of pregnancy in the majority of women of childbearing

When discussing the health education of the pregnant woman these facts must be borne in mind, for the first principle of good health is that the mind should not disturb the nervous system by doubts, anxieties, or major fears. The problem resolves itself into two lines of thought: first, the efficient preparation of the body for the purely physical function of childbearing and, second, the education of the mind to prevent the innumerable insidious ailments of pregnancy which undoubtedly arise from ignorance and anxiety.

THE PREPARATION OF THE BODY

This first aspect of the subject must be approached on the assumption that the woman has no knowledge whatever of the physiological and structural changes pertaining to childbearing and no understanding of their purpose. In the past it has been customary for women to be told nothing by expert teachers, but to assimilate hearsay and inexpert advice from women who have had

babies or even those who have not had babies.

For purposes of clarity we must consider three aspects of physical education: the simple hygiene of pregnancy, physical exercises, and relaxation.

Simple hygiene: From the earliest months of pregnancy a woman should be told of the necessity for regular habits. The need for easily assimilable foods, and the avoidance of hot fats and other gastric irritants should be stressed. Her attention should be drawn to her clothing so that as she increases in size her posture may be retained without throwing undue strain on the muscles of the back, abdomen, and feet. She should be told how to support the breasts so that she may move easily and breathe freely and at the same time retain her figure when lactation has finished. There is no reason why any woman should have a less presentable figure after childbearing than before.

Exercises: It is not easy to persuade women of the necessity for physical fitness during pregnancy as a preparation for labor, but experience has shown that women who are properly prepared by physical exercises and respiratory movement have their babies with less difficulty than those whose muscles and joints have been occupied only in the routine of ordinary domestic life. Certain discrimination is advised, however, in the exercises to be performed, for they are designed not to develop the muscles but to attain maximum flexibility over their full range of action. Movements, particularly of joints, are for the purpose of mobilizing joint surfaces so that, as labor progresses, the natural strains and forces can be utilized to the best mechanical advantage. Full inspiration and controlled expiration is important. The muscles of the abdomen and the back should be regularly

MAY, 1947

exercised. The mobility of the vertebrae and of the joints of the pelvis can be increased by simple rocking movements which may be performed on the back, on all fours, or in the

kneeling-squatting position.

Although the details of these exercises vary according to the different schools of physical education, the fundamental principles and their importance have happily been recognized by most of the important schools, so that minor differences of opinion may cease. As a general criticism it may be said that physical exercises are definitely worthwhile, not only because of the wellbeing and sense of fitness that the mother experiences, but also as an adjuvant during parturition. physical fitness alone cannot produce easy labor. It is only one factor in the preparation for childbirth. This must be emphasized because, recently, claims have been made by writers in women's journals that physical culture provides the panacea for all the ills and woes of childbirth. Such claims lead only to acute disappointment for those who accept and act upon them.

Relaxation: It has been shown of recent years that the result of anxiety, both during pregnancy and in labor, is a state of tension in all structures supplied by the sympathetic nervous system. Morning sickness, vomiting, headache, small but noticeable rise in blood pressure, vicarious appetite, frequency of micturition, sleeplessness, irritability, and depression may all arise entirely or in part from increase of neuro-muscular tension. Far more important than these troublesome interventions, however, is the little recognized fact that the pain of normal labor is almost entirely due to abnormal tension. More will be said of this when we discuss the education of the mind, but physical relaxation is an important factor, not only in the maintenance of good health during pregnancy, but also in minimizing the pain of labor. It is simple to teach and, up to a standard sufficient to be of help, is acquired in a short time by a large majority of women.

The principle of relaxation is to adopt a position in which all the muscles of the body may be flaccid, immobile and, so far as possible, without tone. The woman should lie on her back with her feet six inches apart, her hands four or five inches from her side, her head turned over to right or left supported on a pillow. The practice is commenced by four or five deep inspirations, expiration being neither forced nor controlled. The lungs should be allowed to deflate freely. She then lies completely still, the instructor, if present, paying particular attention to the face, which should lose expression with gently closed eyes and partially open mouth. The weight of the arms may be appreciated if they lie loosely by her sides and the legs, with the toes falling outwards. will give the feeling of pressing down on to the bed or floor on which she is lying. All movements should be avoided, such as flickering of the eyelids or twitching of the fingers or toes. With very little practice this position may be maintained for ten to fifteen minutes and, when an instructor is present, the efficiency of relaxation may be tested and faults corrected. infrequently women will go to sleep after a very short time and such sleep is likely to be restful, dreamless, and undisturbed. The best times for relaxation are in the middle of the day and upon going to bed at night, and it is most effective if carried out after the exercises have been performed.

The application of relaxation in labor is to avoid all tension during contraction in the first stage, for neuro-muscular tension of the skeletal muscles is undoubtedly associated with an increased tension of the constrictors of the lower uterine segment, and if from any cause the woman herself is in a state of tension, the dilatation of the cervix by the longitudinal muscle fibres of the uterus is subject to increased resistance. In the second stage of labor, relaxation between the contractions not only increases the rate of recuperation but also

intensifies the natural amnesic state which is a physiological provision to minimize exhaustion from the violent physical effort of expulsion.

The physically fit woman trained in the art of relaxation almost invariably has a quicker and less distressing labor than a woman who is not physically fit and who remains in a state of neuro-muscular tension. But again emphasis must be laid upon the fact that relaxation is only an adjuvant to natural labor and by itself is not sufficient to give the best results.

THE EDUCATION OF THE MIND

This is undoubtedly the most important part of the prenatal education, for the woman who is taught about the processes of childbirth and who experiences its changes with neither surprise nor dismay but who appreciates the significance of the series of natural events as they develop, has every chance, in the absence of complicating features, of producing her child easily and happily in a state of physical fitness and mental equilibrium. No man or woman in modern civilized communities is expected or invited to undertake an important task without reasonable instruction, and yet for centuries woman has been asked to carry out this most momentous task, unguided and uninformed. It is not unnatural that labor has earned an unjustifiably evil reputation.

From the beginning of pregnancy, therefore, every woman should be instructed in a simple way. should be told the elementary anatomy and physiology of her organs of reproduction and thereby have reason to respect and care for them. As the infant grows, she should be kept aware of the necessities for its protection and nutrition and should have at least a rough idea of its size. With the advancing months new facts can be given to her, and her fears eliminated by honest instruction. The beliefs of the past should be replaced by the realities of the present. The necessity for physical preparation will dawn upon her and an interest in her condition, her baby, and the conduct of her labor will alter her whole attitude towards childbirth. She should have someone whom she may question so that no doubts can form a background of anxiety in her mind.

By the thirty-eight or thirty-ninth week she will be ready to rehearse the actual position in which labor is conducted. She will be acquainted with the manner of its onset and the signs by which she may recognize its commencement. She will be told of its stages and how pain can be both prevented and caused. The importance of her physical training and the practice of relaxation will dawn upon her, and almost invariably the average woman will look forward with determination to carrying out her labor according to the law with which she has been made acquainted. She develops confidence through understanding; she develops faith in her attendant, particularly if the instructor may be present at her labor; but, most important of all, she looks forward without apprehension, not to a simple affair to be taken frivolously, but to a day of honest hard work, concentration and control, which will enable her to avoid both pain and danger and protect her child from unnatural interference.

RESULTS OF PRENATAL EDUCATION

This prenatal education, both of the body and the mind, is already being undertaken at a number of antenatal clinics throughout the country. It has been found that very little extra time is needed, particularly if some of the redundant and unnecessary items of routine are dispensed with, and the results obtained have already more than justified any reorganization which may have been necessary.

There is no class in obstetrics—from the illiterate to the most highly educated similar variations will be detected. Taken by and large, one of the most surprising observations is the ability of all women to understand such education as has been described above. A pregnant woman has

a mind that is reaching out for information about childbirth and, although different words may be used to different people, the comprehension of these matters is remarkably facile. Where this instruction is given, usually in classes of twelve at a time, the whole atmosphere of the antenatal Women arrive clinic is changed. cheerfully with obvious buoyancy of spirit with a demand to know more and to improve their educative technique. A large majority of them appear, as indeed they are, cheerful enthusiasts whose anxieties have been cast like a burden from their shoulders: they have become bored with waiting during the last fortnight; they have become exhilarated when they recognize the onset of labor.

If labor is conducted with full knowledge of emotional as well as physical changes it presents a new picture of parturition. It becomes a peaceful, quiet performance with the pain period only noticeable at the stage of transition from the first to the second stage. The woman will have been forewarned of this and will have realized that it is a temporary discomfort which will be relieved if she considers it unjustifiably intense. She will be told that when the birth canal is open wide enough to allow the child to be expelled, her uterus will call upon her to give involuntary and strong assistance. If the phenomena of labor have been outlined to her beforehand she will not be, as most untrained women are. in a mental turmoil, anxiously awaiting the worst and unbearable pains which they believe to be inevitable.

In a series of a hundred consecutive deliveries of trained primiparae and a hundred cases of unprepared controls recently conducted at one of our universities, labor was over four hours shorter in the trained class than in the untrained. Minnitt's analgesic apparatus was offered to and available for all the women. It was used by 5 per cent of the educated and 76 per cent of the uneducated. This difference was not due to gallantry or to loyalty to their teachers, but because they neither needed nor

wished for it. There is little doubt that these results would have been even better had the attendants also been trained in the conduct of physiological labor, but they were not and consequently much of the antenatal education was robbed of its advantages.

There is no reason why this important training should not be carried out wherever antenatal clinics are held. Although it has been adopted by many, and it is rapidly being organized by more, this great campaign, not only for the relief of suffering in childbirth but for the fearless happiness of motherhood, must be encouraged. There is no justification for the denial of these benefits to women. Physical Training Colleges (in Britain) are prepared to give special courses for the instruction of teachers in obstetric physiotherapeutics who will be competent to attend women during labor. With the shortage of nurses it will be of assistance in our maternity departments where women under present conditions have to be left alone for many hours during the first stage of labor. Loneliness, mental or physical, is one of the causes of painful parturition.

There is evidence from all over the English-speaking world that this teaching has brought safety and happiness in motherhood. It is hoped that in the near future one of the fundamental principles of obstetrics will be that all women are educated and prepared for the fulfilment of their ultimate perfection as the females of the human species.

BIBLIOGRAPHY

Grantley Dick Read, M.A., M.D., (Cantab.): Author of "Natural Childbirth," "Childbirth without Fear," "Revelation of Childbirth," "Influence of Emotions upon Pregnancy and Parturition" in Browne's "Ante-natal and Post-natal Care," "Mother-hood in the Post-war World," "Correlation of Physical and Emotional Phenomena of Natural Labor."

The above article, supplied by the League of Red Cross Societies, is reproduced with the kind consent of the author and of the Central Council for Health Education.

Delivery Room Technique

GERTRUDE ARMSTRONG

THE DELIVERY ROOM service is by I far the most important part of the Obstetrical Department. It must be well organized, and the equipment and supply of linen must be sufficient to ensure an uninterrupted twenty-four hour service. The staff of graduate nurses must be qualified and experienced, and the student nurses well supervised. The whole personnel must give of their best at all times, for in no other part of the hospital do the combined efforts of physician and nurses mean so much to the patient's welfare, as a split second may sometimes spell life or death.

Our hospital has a large Prenatal Clinic, where expert care and advice are given to expectant mothers, but we still have a great many emergency cases come to us who have had

little previous examination.

Nurses on duty in the Delivery Room wear gowns over their uniforms, tight-fitting caps and masks which are discarded after two hours' usage. Each patient is provided with individual equipment: bed-pan and tray for perineal care. These and all linen are autoclaved. The mattresses and pillows are covered with detachable rubber sheeting, which is easily washed with soap and water after each patient is delivered. All patients' clothes are listed and placed in a locker room adjacent to the Admitting Room, thus eliminating any outside contact.

When a patient is admitted to hospital, she is first examined in the Admitting Room by an interne, who, having previously looked up her prenatal record, observes her physical condition, does a rectal examination, takes her blood pressure, and examines a specimen of urine. The abdomen is palpated and the fetal heart sounds counted. All these findings are recorded on the "Labor Sheet."

The nurse, wearing a gown, then proceeds to prepare the patient for

the Labor Room. If time permits, a sponge bath is given, the hair is fine combed, an enema given, and the pubes shaved. The patient is then taken to the Labor Room. The nurse puts on a fresh gown, scrubs her hands, and proceeds with the preparation of the patient.

All equipment for the "scrub up" used for the patient on admission to the Labor Room, preceding a vaginal examination and at time of delivery, is kept on special tables which can be easily wheeled from room to room. Each table is covered with a sterile towel folded so that half of the towel covers the equipment which consists of: 1 hand towel; 1 pair rubber gloves; 5 pad filler squares; 2 bowls (one filled with green soap and sterile water and the other with Dettol Solution 2%).

Perineal care is given each time a bed-pan is used. The pulse, temperature, respiration is taken q.4.h, and all intake and output charted. The fetal heart is noted by the nurse q.15 min. All care and contacts with the



The stirrup in use

MAY, 1947



Delivery boot-side view

patient are recorded on a "Treatment Sheet" designed for this purpose.

Immediately before delivery, Dettol Cream 30% is applied to the perineum, and the patient is catheterized with a rubber catheter.

The delivery stirrups consist of straight padded poles and a pair of washable boots. These delivery boots are zippered over the cotton stockings and suspended from the upright bars by means of a strap attached to the boot. The zippered boot permits easy manipulation and prevents the foot from slipping out of the stirrup. The straps are sewn to the sides of the boot so that

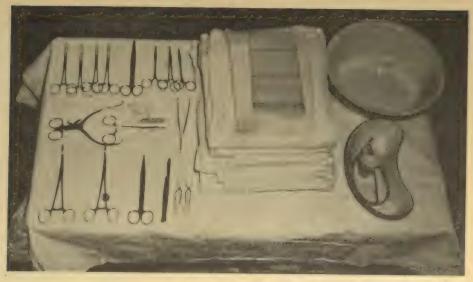


Delivery boot—front view

pressure is distributed over the plantar surface of the foot. There is no circular pressure around the foot or the ankle as in other methods. When the patient "bears down" her feet are supported and the cramping



Draping of patient and equipment



· The instrument table

Hayden, F.R.P.S.

muscular spasms of the legs are eliminated. She also has mobility of the legs when awake. When the patient is anesthetized the legs become abducted by their own weight. These boots are inexpensive, washable, and comfortable. The accompanying illustrations show the type of delivery boot which we use. They have been adapted from the style used by Dr. J. B. Pastore.*

The following packs are used in the

Delivery Room:

A. For vaginal examination: 1 draw sheet; 1 small perineal sheet; 1 hand towel; 1 vulva pad; 5 gauze sponges.

B. For delivery: 1 large sheet (fan-folded to cover table while awaiting delivery and later used to cover baby's cot); 1 pair leggings; 1 square sheet for use under buttocks; 2 draw sheets (one for each leg); 1 square sheet doubled (this is used to cover abdomen); 1 large towel (placed across the perineum); 1 cotton bag containing gauze sponges and cord ties; vulva pads.

N.B. This type of draping prevents contamination if patient is restless and not deeply anesthetized.

C. Equipment: In a special double cover,

* Reference: "A Satisfactory Leg Support
for the Lithotomy Position," John B. Pastore,
M.D., Department of Obstetrics and Gynecology, Cornell University Medical College
and the New York Hospital.

opened at side and end, are placed: 1 hand basin; 1 placenta basin; 1 kidney basin; 1 specimen bottle for urine.

This covering is used as a hand basin stand drape which can be kept covered if necessary until needed.

D. Instruments: The instrument table is set up as shown in the accompanying illustration. We keep a photograph of this table set-up in every Delivery Room; this has proved a great saving of time and helps the student nurses.

A large blackboard is placed on the wall in the corridor of the Delivery Room Suite — the headings covering the progress of labor for each patient are shown in the cut. This is valuable for the teaching of nurses and medical students, as well as a source of information for the doctors and nurses, and lessens the number of contacts which otherwise would occur.

If the new-born infant does not breathe spontaneously assistance is given immediately. The air passages are cleared of mucus with the aid of a mouth suction tube. Breathing may be stimulated by means of resuscitating tubs, resuscitating machine, or gentle massage of the chest. Oxygen 95% and carbon dioxide 5% or oxygen may be given to further stimulate breathing. Alpha lobelin, coramine, or adrenalin may

BED.	NAME	RAI	ONSE PAIN TIME	2EG.,	R	mB	PRINS:	CHARACTER	FREQUENCY	SHOW.	FOE HEA	TIME	Position	DRES PART	DATE	MEDICATION	REMARKS	Examinee	Time.

be injected as ordered by the physician.

Good case room technique demands a great deal of forethought; it means the conservation of time and energy, and plays a major part in assuring better nursing care to the mother and her new-born child.

Homestead Obstetrics

BETH LAYCRAFT

Is IT A CITY HOSPITAL with elaborate and fine equipment, with anethetists, doctors, and nurses galore? Or is it a homestead cabin with a few simple instruments set up on a dresser with the husband and a neighbor woman to help the nurse? Basically the objects are the same — a healthy mother and baby with a maximum of safety and comfort. We Alberta District Nurses sometimes find ourselves in the second set-up and I am going to outline briefly what we do in this area where doctors are so scarce.

I will take you through a pregnancy with an imaginary Mrs. John Smith whose case is typical. Mrs. Smith, a twenty-two-year-old primipara, comes to see me in the second month. She is obviously both frightened and pleased by her pregnancy.

Much depends on this first visit. If it is well handled Mrs. Smith will receive guidance and help through a critical period and, equally important, she will place her confidence in

the nurse and seek her counsel in other family problems. Regardless of the pressure of other business I never hurry this first visit. First a careful medical history: infectious diseases, rheumatic fever (beware the heart!), serious illnesses, operations, pertinent family history. I check the temperature and pulse, take her weight and height. Is her thyroid enlarged? Teeth or tonsils need attention? Any varicosities? Breasts seem normal? How is she sleeping? How is she eating? Any nausea? I estimate her hemoglobin and take blood for a Wassermann.

I take the pelvic measurements. If the nurse is not accustomed to using a pelvimeter a well-illustrated text will guide her. I measure the interspinous, intercristal, intertrochanteric, external conjugate, and bisischial diameters. At the fifth or sixth month when vaginal examination causes little discomfort, I estimate the diagonal conjugate.

This measurement is considered the most important.

The old women have already scared Mrs. Smith half to death with their tales and she is too shy and frightened to ask about the things that trouble This is where I can help by bringing some of the problems up. She wants to know if she can have marital relations? Is it true a fright will mark her baby? What about rest and exercise? What should she eat? As soon as the first barriers of shyness are down the questions pour out. I take plenty of time and

answer them carefully.

I don't forget that there is a father in this family too. Very often at this time the father feels crowded into the background and his place usurped. I draw Mrs. Smith's attention to this and she will handle the rest. I like to discuss her condition and the care she needs with him too. When Mr. Smith undertakes to supervise his wife's health, under the tutorage of the nurse, it may be understood she will not vary much from the prescribed course. if he is personally responsible (taught by a smart wife) for the bottles and diapers, and sometimes even for the morning bath, it is a lucky baby and lucky parents too.

I give Mrs. Smith a copy of the Canadian Mother and Child and some literature on diet and baby care which she and her husband will read to-

gether.

At each monthly visit I check her weight and blood pressure, do a urinalysis, determine the height of the fundus, the baby's position and the frequency of the fetal heart. Minor disorders are attended to; anything serious is referred to the doctor. Iron and cod liver oil are added as needed to her diet.

After the seventh month I like to see her more often. If the distance is great and the roads rough (as they often are in northern Alberta) I would consider it unwise for her to travel but would try to visit her and would have her husband bring a sample of urine and word of how she is feeling.

At eight and a half months Mrs. Smith is feeling very well. The baby is in the L.O.A. position and appears to be of average size. Rectal examination reveals that the head is engaged, that is, the bony presenting part is within 1 cm. of the level of the ischial spines (the baby's head is the best pelvimeter). There are no contraindications to home delivery such as pelvic disproportion, malpresentation, symptoms of toxemia, or bleeding, and I agree to take the case. If there was any reason to anticipate trouble I would send her record to the doctor and ask her to go to the hospital for her confinement.

During the last two weeks she takes one vitamin K capsule daily—a cheap and easy precaution for both mother and baby against hemorrhage.

I explain the symptoms of the onset of labor and tell her to call me as soon as labor is definitely started.

I like to see the home before the time of delivery and at Mrs. Smith's I find a one-room log cabin. There is a good lamp and a bed with good springs and a firm mattress. Her mother, Mrs. Croft, who lives near, will come to help her when labor

The maternity bag is a sturdy overnight bag, 18 x 12 x 6, with a snap-in cotton lining. A "sterile" technique is practically impossible in our bags but a "clean" technique is strictly carried out. The bag from the lining out is packed fresh after each case with clean, ironed linen, and freshly boiled instruments. Nothing is used which has not been boiled since the last case.

EQUIPMENT

In the maternity bag we carry:

2 large enamel basins about 8" diameter; 1 small enamel basin; 2 large kidney basins; 2 Papricloth sheets (heavy sterile wax paper); 1 safety razor and blades; 2 catheters - soft rubber; 1 Murphy drip bulb with a catheter to be used as a mucus suction tube; 2 rectal gloves with a powder puff and lubricant in a small box; 3 pr. rubber gloves - two to be boiled and an extra pair in case of accident;

3 masks, one for the nurse and one for two assistants; 1 gown.

1 many-tailed binder; 2 hand towels; 1 chloroform mask; 1 chloroform dropper; 1 hypodermic syringe, hypodermic and intramuscular needles, suture needles; 1 nail brush; 2 medicine glasses; 1 baby scale; 1 clinical thermometer; 1 rectal thermometer; 1 eye dropper; 1 sterile jar, cord tape; 3 obstetrical sutures in glass vial; cord powder; 1 test tube for cord Wassermann.

Instruments: 1 pair scissors; 4 cord clamps (extra two in case of twins); 1 needle driver; 1 toothed tissue forceps; 1 ring forceps.

Solutions: Green soap; Dettol; Dettol Cream; alcohol; olive oil.

Drugs: Silver nitrate 1% in wax capsules; chloroform; castor oil; local anesthetic; ergotrate tablets; quinine gr. v; aspirin compound with codeine gr. ½; Synkamen capsules (vitamin K).

Hypodermic drugs: Morphine gr. ¼; Demerol 50 mgm.; ergotrate ampules; pituitrin ampules; coramine ampules; Synkamen ampules.

Sterile supplies: Vulva pads: 2 packages of 4's, usual size, 2 packages of 2's, 4" x 8"; pledgets; gauze squares to be used for cord dressings and wiping eyes, nose, and mouth of baby.

Other articles which may be carried in the Stanley bag are: sphygmomanometer; stethoscope; bivalve speculum; paper towels; pencil and paper.

In a separate bag, I carry a bed-pan in its own cover, a Kelly pad, and a bundle of newspapers.

THE DELIVERY

Mrs. Smith begins labor and calls me. She has been having pains for four hours and rectal examination reveals that the cervix is half dilated. I check the L.O.A. position, count the fetal heart, and take her blood pressure. I shave the vulva and give a soap-suds enema. If the bladder appears distended and she is unable to void, I catheterize her.

Mrs. Smith keeps about during first stage and shows me the baby clothes. I show her and her mother, who has arrived, how to sterilize the pads by baking them in the oven in a small sack for half an hour at about 300° F. Then we get something to eat. All this distracts her atten-

tion and helps her to relax while the cervix is dilating.

If it is needed, I give 100 mgm. of Demerol. A repeat dose of 50 mgm. may be given three or four hours later. I do not give any sedative if I expect the delivery within four hours. A surprising number of cases need no sedation.

I get everything ready for the delivery in plenty of time. I put water to boil in one large basin and cover it with the other. A saucer is boiled in this basin to remove clots and debris from the bed after the delivery. Just before I scrub, I uncover the basin and add Dettol to the water to be used as a sterile hand basin. In the other I put sterile pads, absorbent and dressings. In one large kidney basin, covered by the second, I boil instruments. sutures, syringe, needles, and a medicine glass. Later I fill the medicine glass with Dettol Cream. The second kidney basin will receive the placenta. I boil an extra pair of gloves in a saucepan for any unexpected emergency.

Mrs. Smith prepares the baby's basket and tucks in a hot water bottle.

When rectal examination reveals that the cervix is fully dilated I instruct Mrs. Smith in bearing down. If the second stage is progressing slowly it often helps if, during the pain, she assumes a squatting position like that used by many primitive women (it increases the diameter of the outlet and assists her bearing-down efforts). Patience and gentleness are the nurse's best qualities.

For the delivery I like the bed raised to a table height by placing twelve-inch blocks under the legs. The patient lies transversely across the bed with the buttocks close to the edge. Two chairs at the edge of the bed with pillows across the backs will make stirrups. I put warm stockings on the patient and a blanket across her chest and arms. I prepare the sterile field and just before I scrub I slip the sterile Papricloth sheet under her.

I put only one ounce of chloroform (for everyone's protection) in the drop-bottle and show Mr. Smith how to drop it on the mask. I will direct him to give it for the last few pains during the birth of the head.

Remembering that the helpers are the greatest potential source of infection I explain what is sterile and why they must not come near it. They co-operate very well. I give them each a mask and ask them to put on clean aprons.

I put on a cap and a clean (not sterile) gown and then scrub. A small amount of soap left on my hands will permit the wet gloves to slip on easily.

In the District, it seems wise to avoid episiotomies or tears if possible, so we keep the head on the perineum until it is very thin. I keep the head well flexed until it is crowned and then between pains allow it to extend slowly and the head is born. I wipe the nose and mouth and note the head will turn right. I cannot feel the cord around the baby's neck. I grasp the head and turn the baby so the shoulders are in the antero-posterior diameter of the outlet. I draw the head down to bring the anterior shoulder under the symphysis and then raise it gently to avoid a tear by the posterior shoulder and the baby The suction tube and catheter clean the nostrils and throat. I tie the cord about two inches from the abdomen and then fold it back and, using the same tie, tie it again. If it should tend to bleed there is still room to tie it again.

I always give the new-born baby to its father to be put in its basket. And isn't he proud to be the first to handle it! I can hear him clucking and talking baby-talk to it while I tend to the placenta.

A hand on the fundus. It is firm and hard. I inspect the perineum. Good! no tear. There is a gush of blood and the fundus rises up in the abdomen. Now a whiff of chloroform while the placenta is born. When it is at the vulva I grasp it with both hands and turn it gently till the membranes are detached. I examine both the placenta and membranes to be sure they are intact and take blood for a cord Wassermann.

POSTPARTUM CARE

Mrs. Croft helps me move the patient into a comfortable position and I show her how to hold the fundus while I tend the baby. The bleeding is not excessive but I usually give an ampule of ergotrate to be sure.

The baby is a vigorous boy—seven pounds ten ounces. Silver nitrate 1% for the eyes. No tongue tie, genitals appear normal, anus open. I clean him as much as necessary but do not remove the vernix caseosum. The cord is sponged with alcohol and a sterile dressing applied. I dress him and put him in bed with his mother. He will go to his own crib before I leave.

Everyone is hungry, including the new mother, and we all enjoy a meal. This extra hour before I go is another hour in which I can watch the mother and baby.

I leave the following instructions with Mrs. Croft for Mrs. Smith's care:

Pain: If she is in pain give her one "pain tablet" every four hours if necessary. (I leave six aspirin compound.)

Bleeding: Give one "bleeding tablet" (ergotrate gr. 1/320) morning, noon, and night for two days. The uterus can be felt like a round, hard ball in the abdomen. It goes down about one to two inches each day. After delivery it is at the navel. It should never rise above it or become soft. If it does there is probably bleeding inside even though the patient may not be flowing much. If there is either a large, soft uterus or more bleeding, give a tablet immediately and rub the uterus gently until it becomes hard. (Before I leave I make sure that this is well understood.) Send for me unless the bleeding stops immediately and the uterus stays low and hard.

Bowels and bladder: A full bladder displaces the uterus and slows its return to its normal size and position, so give the bed-pan at least every four hours. Do not put it on the floor as it will take the dirt from the floor to the bed where the patient lies.

After emptying the bladder the patient may use toilet paper. After a

bowel movement the assistant should wash her hands and then with soap and water and a clean towel and cloth very carefully wash away from the vagina. Be careful that nothing goes inside. (We find that in untrained hands the usual hospital perineal care is poorly given and may be a source of infection.)

If the bowels have not moved by the second day give a mild laxative. If they have not moved by the next

morning give her an enema.

Care of the breasts: If the breasts are heavy support them "up and out in the shape of a pear" by a binder. A piece of absorbent cotton or half of a pad under each breast will help. Make broad firm straps for the binder and adjust their length by a safety pin.

Wash them with soap and water before the baby nurses. Keep a cloth

and towel separate for this.

Put the baby to nurse on alternate breasts for not more than two minutes every six hours until the breasts fill, then every three hours during the day and every four hours at night. The baby will go on a four-hour feeding itself when it is ready.

Diet: The mother may have light nourishing foods as she desires them plenty of fluids and milk. If the breasts become painful and hard, lessen the

fluids for a day.

Visitors: No visitors until after the fourth day. The mother needs rest and neither she nor the baby should be exposed to sore throats and colds which visitors may bring.

Danger signs: Send for me immediately if any of the following occur or if anything else seems wrong with

the mother or baby:

Pain in one breast (engorgement will

be in both); excessive bleeding; abdominal pain and a general sick feeling; pain in one leg; fever and chills; failure to pass water within twelve hours; bleeding from the baby's cord.

Care of the baby: Wash the buttocks with water and soap when necessary but do not bath him for six days. Change the binder if it becomes wet or soiled. If the dressing becomes wet, wash your hands thoroughly and put on a fresh one.

I return on the third or fourth day to check the mother's progress and to start her exercises. As there is a tendency for women in their own homes to go to work too soon I like them to stay in bed for nine days. If I can, I make another visit then for health instruction and supervision.

In six weeks, Mrs. Smith comes for a postpartum examination. She is feeling and eating well and is doing her own housework. She is nursing the baby and there is plenty of milk. Her weight is slightly more than in her pre-pregnant days. The cervix appears normal. The uterus cannot be palpated above the symphysis and there is no vaginal discharge. I put the baby on the usual Well Baby Clinic care and ask Mrs. Smith to come for another check at six months. Then I will finish her obstetrical record and file it for future reference.

We district nurses take much pleasure in this part of our work and find it makes a valuable contribution to public health.

BIBLIOGRAPHY

Beck. Obstetrical Practice.

Eben, Barbara. Obstetrical Manual for District Nurses.

Pain

Pain arising from the skin can be accurately localized. Pain from visceral disease cannot be localized with the same degree of accuracy because the nerve-endings are segmental in distribution. Pain is localized on the skin because the cortical analyzer has been educated. The skin can be seen, and as the

cortical analyzer gains experience, it learns to localize skin pain accurately. In the case of deep pain there was not that learning by sight combined with experience, and the area in which pain is felt depends on the general sensory nerve distribution.

-Nursing Times

Care of the Unmarried Mother and her Child

N. W. PHILPOTT, M.D. and CHRISTINA F. GOODWIN

TRADITIONALLY, unmarried mothers have turned to the medical profession for help and advice. They have looked for an unprejudiced attitude towards their problem, a safeguarding of their confidence, and practical assistance for themselves and their babies. They have asked a great deal of the profession and doctors have not

shirked their responsibilities.

Gradually, another profession has been growing up — that of social work - to which doctors have been turning. Today some social workers give all their time to the problem of the unmarried mother and her child. They are ready and, in many localities, are working with the doctors to provide the best possible solution for mother and baby. As the doctor thinks of each patient individually and plans according to her particular physical needs, the social worker gives consideration to each unmarried mother's social and emotional needs. This is an age of specialization, and doctors, most of all, are able to see the necessity of assistance for the unmarried mothers and their babies from a profession specially trained and experienced in this very difficult work.

Unfortunately, there have been few funds available for research on the effects of unmarried parenthood, on the success of adoption or of the mother retaining the responsibility of her child. It is, therefore, impossible to make statements about what plans are best in the majority of cases but we can put down some basic principles on which we work.

We believe that every unmarried mother should have freedom to choose whether she will keep her baby or give it up for adoption. This in-

Reprinted, with permission, from The Canadian Medical Association Journal: 55, 293-295, 1946.

volves a great deal, as it implies that she will not be forced to a decision through economic necessity alone; that she will not be advised in such a biased way that the decision is really that of her adviser; that fear, shame, and guilt will not weigh so heavily on her that she cannot think through her problem. These patients are in a defenceless position where they may very easily be influenced to make hasty decisions which they will regret all their lives. The doctor is in a strategic position to guide them towards resources in the community where they may get help to make it possible for them to delay decision till they are fit for such an important task. In most cities in Canada there are private agencies who specialize in these services and in most provinces the Children's Aid Societies cover even the rural areas. In hospitals, which have social service departments, much help may be secured through them for the unmarried mother.

Doctors recognize that all pregnant women have some psychological and emotional problems. A woman, who does not have the normal support and protection of a husband but who has very often a sense of guilt and shame, a feeling of bitterness towards the father of the unexpected baby, or towards parents who have not prepared her to avoid such a tragedy, has much more complicated psychological and emotional problems. Sometimes these are so severe that she needs help from a psychiatrist. It is true that few unmarried mothers are in condition to decide the fate of their babies until they have recovered from their confinement and are normal physically. They need to have full information as to the resources available to them and particularly to

MAY, 1947

know just what will happen to the baby should they give it up for adoption. Some mothers, who have no contact with their babies after birth, later make efforts to trace them, an evidence of an unsatisfied need and sometimes a continuance of a feeling of guilt. It should be recognized that an unmarried mother, in addition to the physical pain of giving birth, has psychological suffering which is not so quickly forgotten. It is probably true that if the mother sees her baby, does something for it such as feeding it while in hospital, or paying what board she can for it till it is given up for adoption, she may overcome her feeling of guilt. Some psychiatrists teach that you must possess before you can give up. This may well apply to the unmarried mother.

It is important that those who try to help the unmarried mother should understand her motives in making decisions and should be able to interpret them to her if they are unsound or unhealthy. You cannot assume that love or hate of the baby always lead to the same end. Some mothers give up their babies because of an honest belief that it is in the best interests of the baby. Others do so because they reject them as visible evidence of their feeling of guilt or because they associate the baby with its father, towards whom they feel bitterness. The social worker can help the mother to think of the baby as an individual for whom they should plan to the best of their ability. They direct their emotions in healthy channels and facilitate their return to a normal mental and emotional condition.

Sometimes relatives and friends put pressure on the unmarried mother in making her decision. They may overprotect her with the idea that she should forget all about the unfortunate experience, or they may try to make her feel guilty if she decides to give up the baby, as "no baby should be separated from its mother" or "nothing would make them give up their baby." Even should they give up their babies

they still need contact with a professional worker in whom they can confide their worries and who can reassure them as to their decision.

It is difficult to make any definite statements as to what type of mother can succeed in making a fairly normal and happy life for her baby should she keep it. Those who marry and whose husbands adopt the babies are sometimes successful. If the mother is emotionally stable and the conventions of her family and social group are not too violently critical of illegitimacy, she may succeed in bringing up the child in her parents' home. The occasional gifted woman can manage to make a home for herself and her child alone.

When the mother decides to give her baby for adoption she should be advised to do so through recognized agencies or welfare departments of the Government, which are professionally staffed. The selection of adoptive parents, the placement of babies in suitable homes, and the supervision of the babies until adoption procedures are completed, is a very difficult task which should be done by professional persons trained for that purpose. All doctors must know of tragic cases where insufficient care has been taken to be sure that the couple wanting to adopt a child is fit or capable of looking after it, or where the baby has not been fit for adoption. Some childless women become so emotionally unstable in their anxiety to have children that they cannot give a baby a normal, secure environment. Sometimes the husband does not really want to adopt a child, is over-persuaded by his wife, and does not accept the child emotionally. Sometimes there are health factors which render the couple unsuitable as parents. Infinite care should be taken that the baby who, from its family background and elementary intelligence tests, shows potentialities for more than average mental development should be placed with parents of above-average intelligence, who can provide full educational opportunities. Like care should be taken that a baby of only average intelligence

should not be placed with parents who will expect the impossible of him and make themselves and the child frustrated and unhappy. Experience has shown that it is best for the child that foster parents should tell him of his adoption as soon as he is able to understand it. There have been a number of cases in mental hygiene clinics where children were found to be developing behavior problems because of their doubt as to parentage. When this is explained to them at an early age there is the least danger of emotional trauma.

Persons who arrange adoptions must, of course, be conversant with the child protection laws of the province in which this is to be carried through. There have been needless heartaches for unmarried mothers who have been offered this service only to find that it could not be carried through as planned because of some legal technicality, such as

residence regulations.

During 1945 there were 2,438 deliveries in the Royal Victoria Montreal Maternity Hospital. One hundred and one unmarried mothers were capably handled relative to their own condition as well as to the future of the child. This was a combined effort of the medical staff and of the social service department. The majority of cases were attending the prenatal clinics, many referred by agencies, but some were private patients referred to the social service department by their doctors.

All new patients registering at the prenatal clinic are first seen by a social worker and, therefore, the unmarried mothers are very early offered the services they particularly need. No definite plans are made until patients have been examined by the doctor and his recommendations have been received. Sometimes it is necessary to know the patient's fitness for work, or whether her living conditions are suitable to her physical needs. Sometimes a decision must be made as to the advisability of the mother travelling in order to reach a place where she has legal residence and is eligible for financial assistance, or where she may arrange adoption. The doctor and social worker must consult together about these patients on many points and also keep closely in touch with the agencies interested. In Montreal we have four different agencies which look after unmarried mothers and their babies: the Children's Aid Society of Montreal, the Catholic Welfare Bureau, the Bureau d'Assistance Sociale aux Familles, and the Jewish Child Welfare. There is also an agency which takes responsibility only for the babies - the Société d'Adoption et de Protection de l'Enfance. This hospital works closely with all these agencies.

Sometimes the social worker in the hospital must spend a good deal of time and effort to persuade a patient to give her consent to a referral to any agency, but it is always considered worthwhile. Even when the unmarried mother thinks she is capable of planning for herself and her baby experience has proved that she needs this protection. It also protects the baby from being exploited. The public is becoming more and more aware of this danger. As an example, at the Canadian Conference of Social Workers held in Halifax, June, 1946, Miss Maud Morlock, of the Children's Bureau, Washington, told how women eager to adopt babies were coming to Canada from the United States and taking them across the border without any proper supervision. Among other difficulties the children later on find that they have no citizenship rights.

In Montreal, a group of social workers and agency board members have formed a committee on unmarried parenthood, under the Council of Social Agencies, to study such problems and to make recommendations to the authorities for improvement of our Child Protection Laws.

There must still be many unmarried mothers who do not receive adequate prenatal care and whose babies are not placed. Facilities for adequate handling of this type of case should be made available to the whole community and not confined to the larger institutions.

Optimal Nutrition for Patients

H. JEAN LEESON, M.D.

T IS THE NURSE'S responsibility to look after patients' nutrition, because ultimately she is the only one who can make sure that the patient actually consumes the proper amount and the kinds of food prescribed by the physician. The problem is rendered more irksome by the fact that her choice of the patients' diet is limited: in hospitals by the quality and kinds of food prepared in the kitchens; in private homes by economic and other factors. In view of these restrictions the nurse's knowledge of proper nutrition does not ensure that her patients will obtain an optimal diet. However, a clear mental picture of the goals of invalid feeding will enable her to choose the best available from the foods at her disposal, and make intelligent suggestions about improving them.

The nutritional needs of the human body are fundamentally similar throughout life, both in sickness and in health. In certain normal conditions, such as the rapid-growth period of adolescence, pregnancy and lactation, these needs are increased. Similarly in some diseases, such as hyperthyroidism, or long-standing or recurrent febrile illnesses, metabolism is increased and there is need for a larger amount of all the nutrient factors. Conversely, in non-febrile

illness the patient on full bed-rest has a decreased caloric requirement. Certain diseases have a selective effect in increasing the need for one particular nutrient: the most striking example is the huge increase in protein break-down that occurs following burns and other trauma, necessitating a correspondingly high protein In other diseases, such as diabetes, nephritis, and peptic ulcer, it is necessary to modify the normal diet, although from a purely nutritional standpoint such modifications are often undesirable. In the latter instance, it is the responsibility of the medical attendants in charge of the case to ensure that the patient's essential nutrients are somehow being supplied in a form which that particular patient can utilize. The diet of any invalid is not a new combination of foodstuffs, but simply a normal diet modified if necessary to fit the extra needs or individual limitations.

The essentials of such a diet may be stated in quantities of calories, protein, minerals, and vitamins; or, more intelligibly perhaps, in terms of common foods. Canada's Food Rules are an excellent yardstick, and one that is readily available. These are given in the accompanying table. For patients not requiring special diets, they serve as a useful guide in prepar-

Canada's Food Rules

These are the foods for health. Eat them every day.

Drink plenty of water.

- 1. Milk-Adults, ½ to 1 pint. Children 1½ pints to 1 quart.
- Fruit—One serving of citrus fruit or tomatoes or their juices; and one serving of other fruit.
- Vegetables At least one serving of potatoes; at least two servings of other vegetables, preferably leafy, green, or yellow, and frequently raw.
- Cereals and Bread—One serving of a whole-grain cereal and at least four slices of Canada Approved Vitamin B bread (whole-wheat, brown, or white), with butter.
- Meat and Fish—One serving of meat, fish, poultry or meat alternates such as beans, peas, nuts, eggs, or cheese. Also use eggs and cheese at least three times a week each, and liver frequently.

A fish liver oil, as a source of vitamin D, should be given to children and expectant mothers, and may be advisable for other adults.

Iodized salt is recommended.

ing meals. But any person who has tried to feed a fretful, uninterested chronic invalid, with no appetite, will feel that such theorizing is of little value in the face of firm refusal to eat. In fact, most of the patients requiring bedside nursing are either unable or unwilling to take a full diet. The main types may be divided roughly as follows: acute febrile illness: chronic febrile illness: chronic non-febrile illness; fractures, burns, and postoperative cases; postpartum patients. The special problems involved will be considered under these separate headings.

ACUTE FEBRILE ILLNESS

As mentioned previously, fever hastens the utilization of food-stuffs in the body, so that all the nutritional needs are increased. In addition, it is believed that ascorbic acid (vitamin C) combines with sulfonamides, so that it is not completely available for its normal bodily functions. Thus, in many cases, the need for ascorbic acid is disproportionately increased. Since most of these patients require a liquid diet, it is not always possible to supply optimal amounts of all the nutrients orally. Fortunately, the body stores of most of the essentials are sufficient to make up for dietary lacks for a short time. A liquid diet should be as high as possible in calories and ascorbic acid; it should be realized that such a diet is not completely adequate and that it should be given only for a minimum of time. The use of fruit drinks with added sugar, particularly the citrus fruits, supplies both calories and ascorbic acid. Since it is important that the liquid intake be large, the use of salt is advantageous, both as a stimulant to thirst and to prevent salt depletion. This can be given in broth or tomato juice; the latter has the added advantage of a high ascorbic acid content. As soon as possible milk should be added to the diet to supply protein.

CHRONIC FEBRUE HENES

The normal, well-nourished indi-

vidual has sufficient minerals and vitamins "stored" in the body to maintain adequate function for some weeks, even on a very poor diet. However, in a prolonged illness, such as tuberculosis, with hastened destruction of nutrients due to fever. proper nutrition is of paramount importance. Although the old idea of "fattening up" tuberculous patients to the maximum is no longer in vogue, a high caloric diet, rich in all the protective foods, is very important. All too often adequate supplies of fruit juices are available in hospitals only to patients on liquid diets; in a full diet, ascorbic acid is supposed to be supplied largely from vegetables. But vegetables cooked in large quantities and kept hot for some time before serving have a very low ascorbic acid content when eaten. Ample supplies of orange, grapefruit or tomato juice should be provided daily for all patients, as well as plenty of well-cooked vegetables, and raw native fruits in season. Commercial fruit juice concentrates frequently have a low vitamin C content and should be used with caution.

Bed patients need plenty of protein, and frequently lack appetite for large amounts of meat. Milk is a valuable and economical source of protein, and should be given in ample quantities.

It is not possible to give a person with only average appetite large amounts of protective foods unless the non-protective foods are correspondingly decreased. The use of cake, pastry, and other sweets, refined cereals, and soft drinks should be discouraged so that the patient has appetite for meat, milk, vegetables, fruits, and whole-grain cereals.

CHRONIC AFEBRILE ILLNESS

These are mostly elderly patients, with capricious appetites and longestablished food habits which they are unwilling to change. No more obstinate problem confronts the nurse than that of feeding such patients adequately. Bulky foods and very fatty or fried foods should be avoided, since they impair appetite and may cause flatulence. The edentulous patient may find it impossible to chew meat; if even finely minced meat cannot be taken, a high milk intake is indicated to supply protein. The food should, of course, be well cooked and attractively served. If it is well salted, it will be more palatable to most patients and the salt tends to stimulate appetite.

POSTPARTUM PATIENTS

The aim with these patients is simply to furnish an ample diet, high in protective foods, and adequate fluids so that lactation will be successful. Many mothers seem to have been "oversold" on the importance of milk, and it is not unusual to find one who is taking two or three quarts of milk a day, and very little else. It is important that such women should be instructed about a properly balanced diet, with moderate amounts of milk and other fluids, and a good supply of all the protective foods.

Fractures, Burns, and Postoperative Cases

In recent years it has been demonstrated that there is extensive breakdown of protein following any trauma; this is most notable in the case of burns, but also occurs after other injuries, including surgical oper-Because of this destruction of protein, the body stores are much depleted unless a large amount of protein is administered. For this purpose, blood and plasma transfusions and, more recently, preparations of amino-acids for intravenous use, have become an important factor in care of surgical patients. There is no advantage in giving protein intravenously instead of by mouth; if the patient is able to take it by mouth, it is the preferable route. hoped that concentrated preparations of amino-acids, taken by mouth, could be used to give a high protein intake. However, the nauseous flavor of such preparations makes them unsuitable, and present opinion is that food proteins taken by mouth are preferable. In the invalid dietary, the most important source of protein is milk and the amount of natural protein in milk may be greatly augmented by adding casein or egg. "High-protein milk" may advantageously be given as early as possible, in large quantities, to surgical patients.

Ascorbic acid is believed to be a factor in wound-healing; in scurvy, wounds will not heal. There is some evidence in animal research that ascorbic acid is used up with abnormal rapidity after fractures. It is, therefore, advisable to give ample supplies of citrus fruit juices to surgical patients.

NUTRITION EDUCATION

In looking after the feeding of patients, the nurse has an excellent opportunity for nutrition education. Such education is often difficult when people are well. The attitude of 'My father didn't have more than six oranges in his whole life, and lived to be ninety. What was good enough for him is good enough for me" is frequently voiced, or thought. In illness, some of this assurance drops away: obviously, at the moment, the patient is not proving his ability to look after himself without assist-He may be more receptive at this time to ideas about improved food habits. Such ideas need not always be expressed, since the best education is done by example rather than lecturing. By being introduced, perhaps for the first time in his life, to properly prepared, nourishing foods, at a time associated in his mind with recovery from illness, the patient may acquire an augmented respect for the importance of nutrition or, more probably, simply a liking for a well-balanced meal.

Before relinquishing care of her patient, the nurse can perform a useful service by giving him some advice about his ordinary diet. While this is essential with patients on special diets, it is seldom done for others, who often are surprisingly ignorant of nutritional re-

quirements.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Up in the Air with Patients

M. E. GLEADOW

SASKATCHEWAN operates the only exclusive Air Ambulance Service of its kind on the continent. As nurse for the service, I should like to tell you, informally, about some of the more interesting features of my work.

You are probably aware that the only patients we carry are emergency cases. As a result, the Air Ambulance nurse is quite a busy person

while in flight. The relative accompanying the patient usually requires more attention than the patient himself. His concern for the loved one, combined with the nervous condition on a first flight, often make him deathly air-sick. Don't let me frighten you, however, as a person is rarely air-sick unless he is in very low spirits.



Picking up a patient

Saskatchewan From Board Phot.



Putting the patient aboard

Saskatchewan Film Board Photo

Most of our patients are taken to the larger cities in the province, but in some cases the smaller town hospitals have to be utilized.

The polio epidemic caused considerable work last autumn, and we transported many of these patients. During the summer months, the greater part of our work comprises accident cases, which require constant attention while in the air.

The nature of the work is rather exciting due to some element of hazard. Mind you, it's not as bad as many people would imagine. Many frown on aircraft and fear this type of travel. However, it seems that day after day we carry people who have been hurt in accidents, but somehow we just never meet anyone who has been hurt in an aeroplane. It is admitted, however, that we do get some pretty rough rides landing in some hilly fields.

Every day we experience something new. If you are interested, I should like to tell you of some

experiences. One summer day when thunder-storms prevailed, we were between two of the western cities at a nice altitude when a thunder-head was spotted on the horizon. Course was changed to go around it, but just as we were passing it the winds caught us. It seemed that we were going up one hundred miles an hour and down the same speed at the same time.

On another trip, the usual excited waving of the farmer was spotted and a landing in some very rough country was made. I jumped out with my hot water bottles and set out for the farmhouse. A young man met me half-way, and to my query "Where is the patient?", he replied, "There is none here." "Well, why did you wave?" I asked. "Oh, I always wave at aeroplanes," he replied.

We took off from there and went further into the hills where we spotted some people standing around a burning haystack, waving frantically. The field in which we landed bore a marked resemblance to the Rocky Mountains. Again I enquired the whereabouts of the patient. A man stepped forward to tell us the patient, his brother, lived in the valley some miles away. He thought we would not be able to locate the patient's home, and so had lighted the signal fire at his own place!!! He insisted on accompanying us as "guide," but ten feet off the ground he was completely lost.

We have made two trips into the United States, and anticipate more to convey special cases to various points where specialized attention can be given — places such as the

Mayo Clinic at Rochester.

The nurse's equipment consists of a doctor's kit, with the necessary instruments and dressings, stimulants, morphine, sickness cups, bed-pan, etc. A supply of drinking water is also carried at all times.

All I have told you has been the rougher side of my duties as an Air Ambulance nurse, but this work has its good points. There is an intense satisfaction experienced when seriously ill patients have been safely transported to adequate medical attention.

To say the least, the work of an Air Ambulance nurse is anything but routine and I can say without reservation that it is a most interesting and enjoyable position to hold.

Air Ambulance Service

On February 3, 1947, the Saskatchewan Government's Air Ambulance Service celebrated the anniversary of its first year of operation in the midst of the worst snow conditions in years, which resulted in a record monthly total of seventy-eight "mercy flights" during January. Carrying patients ranging in age from new-born infants to grandparents of more than ninety years, the southern section of the service had made 257 flights, had carried considerably more than that number of patients, and had flown about a hundred thousand air miles up to January 30. Its facilities had grown from one plane and three crew members to the present two planes and ten staff members.

Meanwhile, the northern section of the service, operated by planes of the Natural Resources Department largely north of Prince Albert, had completed forty-two flights and had carried about seventy patients. Thus, total flights, north and south, numbered 299 and the number of patients carried greatly exceeded this figure.

The inauguration of the service was typical of its subsequent operations. It was planned to get under way on February 4, 1946. But on February 2 most of the province's roads were blocked by a blizzard. An emergency call came in on Sunday, February 3, and the air ambulance service made its first historic flight. Ever since that time it has been conducting an unending battle

against illness, death, time, and weather. The measure of its success is partially recorded in the books. But, more poignantly, it is recorded in the hearts of patients whose lives have been saved or recoveries speeded and in the grateful hearts of relatives and friends.

Born in the mind of a returned wartime flier, and leaning on the experience of a humanitarian Regina ambulance service operator, who conducted a similar service on a smaller scale before the war at considerable loss to himself, the idea of a government-operated air ambulance has developed into a service which commands the highest regard in Saskatchewan and which has gained fame throughout the continent.

Types of cases vary widely and there are about fifty different diseases and accidents on record. Acute appendicitis cases, chronic illnesses, such as heart disease, maternity cases, and farm accident cases rank high in the percentage of patients carried. During the polio epidemic last fall, a large number of children were flown to the polio clinic at Saskatoon.

One of the two registered nurses goes along on every flight to look after the well-being of the patient. Usually only one patient is carried but up to three, two stretcher and one walking case, have been carried on occasion.

Although 257 flights were made, total number of calls received numbered over four hundred. Even allowing for trips on which

more than one patient was carried, this leaves a number of calls which could not be answered because of weather, terrain, light, or other conditions. Many night calls could not be answered because regulations prohibit night flights' to any except lighted landing fields.

Calls for the air ambulance are usually made by doctors although, when no doctor is available, calls may come from a nurse or a municipal or other official. Quite often a call comes from a doctor who has not been able to visit the patient, but to whom the patient's

condition has been described over the telephone.

For all emergency flights within the province, only a nominal fee of twenty-five dollars is charged the patient, no matter what the distance, although this does not begin to pay the actual operating expenses for even the shortest trip. The provincial government pays the large deficit in operating costs. So far, the co-operation of doctors and the general public in calling the air ambulance only for genuine emergencies has been very good.

Radioactive Isotopes

One of the first peacetime uses to which biproducts of the atomic energy facilities have been put is in the production of "isotopes," tiny radioactive fragments weighing only about one-ten thousandth of an ounce. For the next 10,000 to 25,000 years these peasized units of Carbon 14 will emit 37 million beta particles per second and will be used in research in connection with such studies as: mechanisms by which cancer is produced; dysfunction of the thyroid glands; growth and composition of teeth and bones; utilization of sugar in diabetes; utilization of all essential food components; the turnover of iron in anemic conditions; problems associated with radioactive isotopes themselves.

Scientists contemplate the use of isotopes in two important ways: First, as tracer atoms or "tracers" for following the course of atoms in chemical, biological, and technical processes, and, secondly, as possible therapeutic agents for treatment of certain special diseases. The value of radioisotopes, however, is considered to reside more in the study of the causes of disease than in treatment.

Each atomic element may occur in "sister" forms, called isotopes. An isotope differs from its sisters in the structure of the atomic "heart" or nucleus. The satellite electrons around the nucleus are arrayed the same for each element, hence the "sisters" meet the outside world and behave chemically alike. In addition to the stable sisters of elements which may occur in nature, it is possible by man-made devices, such as a pile or other atomic nucleus bombarding devices, to make isotopes which do not occur in nature and which are radioactive.

Radioactive sisters behave chemically the same as their normal stable sisters. Because

of their radioactivity, however, they can be followed in the processes in which they parti-Various terms have been used to indicate this property by which radioactive sisters can be followed, such as "tracer," "labelled," or "tagged" elements. By this it is meant they can be tagged much as wild fowl are banded to follow their migration. The tracer application is often also explained by an analogy with the use of tracer bullets. A tracer bullet follows the same path and arrives at the same target as a normal bullet but can be seen by the visible radiation which it emits. In the case of a tracer element or tracer isotope, it is "seen" by instruments, such as Geiger counters or electroscopes, which receive and register the radiations emitted by the radioactive atomic "hearts."

Very small organisms or very small virus particles can be followed by highpowered microscopes or by electron microscopes. The tracer element technique permits an even more minute and detailed investigation of chemical and biological processes. In this case, atoms and molecules themselves may be traced and, furthermore, their identity and changes in identity may be followed. This amounts to an "atomic microscope."

In a few cases the tracer bullet isotopes are not only useful as tracer or "atomic spies" but as active "atomic artillery"; in which case the radioactive isotope can be used to irradiate the locations where they deposit. Some influence has been thus achieved in controlling certain forms of leukemia, and polycythemia vera, both very special types of blood disorders. The use of radioactive materials in therapeutic connections is still very much in the investigational stage.

-News Notes No. 49.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Cost Analysis of a School of Nursing

ELVA HONEY and LOUISE BARTSCH

Scientific management in the hospital field is recognized as an impital field is recognized as an important administrative factor. The present crisis in hospitals, due to shortage of staff and constant increase in prices, has stimulated the thinking of hospital administrators along the lines of cost analysis of all departments of the hospital, including the nursing department through which nursing service is provided. The cost analysis in a hospital conducting a school of nursing is complicated by the fact that the nursing department includes both nursing service and nursing education.

Superintendents of nurses have long been interested in making a study of the cost of the school of nursing. However, without the knowledge of the costs of other departments in the hospital it has been impossible for them to estimate the amount spent by the hospital on the school of nursing.

It is apparent that a cost study of an independent school is a much simpler matter than determining the cost of a school of nursing administrated by a hospital to which it has a service obligation. The items of expense of independent schools should serve as a guide in determining the costs in schools of nursing conducted by hospitals which are striving to improve professional standards. Therefore, in attempting the more difficult process of analyzing the cost of a school of nursing administered by a hospital the follow-

ing brief outline, in terms of basic considerations and general procedures, is presented as a guide in undertaking such a study.

BASIC CONSIDERATIONS

- 1. It is a sound business practice for the hospital to determine the cost of all departments within its organization.
- 2. The superintendent of nurses can assist in determining the cost of the nursing department, which is made up of: (a) the cost of nursing service; (b) the cost of nursing education.
- 3. Budget planning will be possible after the above factors have been determined.

STEPS IN PROCEDURE

One would expect that if the cost of nursing service were subtracted from the total cost of maintaining the nursing department, the result would give the cost of nursing education, but students, while being educated, give some nursing service. Therefore, to determine the cost of nursing education properly we must further subtract the nursing service value that the students contribute in the whole pattern of nursing service.

To arrive at the value of student nursing service we have to decide the proportionate worth of students to graduates. This will vary in each hospital and can only be obtained by doing time-studies of their activities.

MAY, 1947

DETAILED ANALYSIS OF COSTS

DETAILED ANALYSIS OF COSTS							
Mixed Staff	All Graduate Staff						
Direct Costs (variable)	Direct Costs (variable)						
 Salaries of instructors " of librarian " of office personnel employed exclusively in school of nursing Classroom expenses Library School calendar and other office supplies Textbooks, uniforms, etc. Entertainment and recreation Affiliation expenses Graduation Part salaries of administrators, supervisors, and head nurses Subsidiary workers Health service and pensions Miscellaneous 	 Salaries of general staff nurses " of administrators " of head nurses and supervisors Recreation Library. Office personnel Office supplies Facilities for in-service education Subsidiary workers Health service and pensions Miscellaneous 						
Indirect Costs (fixed)	Indirect Costs (fixed)						
 Administrative costs Meals Laundry Plant operation (school and residence) Maintenance and repairs Depreciation and insurance Residence personnel Telephones Miscellaneous 	 Administrative costs Meals Laundry Plant operation (residence) Maintenance and repairs Depreciation and insurance Residence personnel Telephones Miscellaneous 						
Total cost	Total Cost						

The Massachusetts General Hospital, for example, estimated the student to be three-quarters the value of the graduate (1932). Dr. Louis Block, in his study for the United States Public Health Service, discovered that this value ranged from 0.4 to 0.9 (1946). The financial value of student nursing service should then be estimated on the basis of the total salaries paid the number of graduates neces-

sary to replace them. It should be kept in mind, however, that, because of classes, the students do not give as many hours of nursing service per day as graduates would; also that affiliation takes the students out of the service for considerable lengths of time. However, in some situations, these students are replaced by students affiliating from other schools.

When the cost of nursing education

to the hospital has been determined, the superintendent of nurses then wants to know the cost of an allgraduate staff in comparison with the cost of the mixed staff of the school of nursing, so that she may know whether the students are receiving more or less than they are giving. The technique used to determine these costs is to list: (1) the full cost of the school; and (2) the full cost of graduate staff necessary to replace the students. These costs should be computed on a one-year basis as this is the smallest unit of time which can give an accurate picture. accompanying table indicates the major items which should be considered in this study.

Conclusions and Deductions

- 1. The difference between these costs, that is, mixed versus all-graduate staffs, will show whether the school is an asset or liability to the hospital.
- 2. If the school is a marked asset to the hospital the students obviously are giving more than they are receiving.
- 3. The superintendent of nurses is then justified in asking the hospital to allocate more to the school.

4. If the school is costing more than an all-graduate staff, it would be *financially* advantageous for the hospital to discontinue it. However, for such reasons as prestige or interest in education, it may be desirable to continue the school. At this point, the question of students' fees, as are charged in all professional schools, could be considered.

On the basis of this cost analysis the superintendent of nurses is in a position to plan a budget which will ensure maximum educational benefits for the school.

BIBLIOGRAPHY

- 1. Block, Dr. Louis, U.S.P.H.S. Approach to a Cost Study. 1946. Report.
- 2. Hersey, Mabel F. The Budget System. The Canadian Nurse, Nov. 1932, p. 591.
- 3. Patterson, Teele and Dennis. A Study of the Yearly Expenses of the Training School for Nurses at the Massachusetts General Hospital. The Bulletin of the American Hospital Association, April 1932.
- 4. Pfefferkorn, Blanche, A.M., R.N., and Rovetta, Charles A., M.B.A. Administrative Cost Analysis for Nursing Service and Nursing Education. American Hospital Association, Chicago, and National League of Nursing Education, New York City.

Coming Events

Registered Nurses' Association of Nova Scotia

Event: Annual meeting.

Date: June 11 and 12, 1947.

Place: Halifax, N.S.

Association of Nurses of the Province of Ouebec

Event: Twenty-seventh annual meeting.

Date: May 26 and 27, 1947.

Place: Windsor Hotel, Montreal, P.Q.

Special note: English program: Panel Discussion on "Labor Legislation as it Affects Nurses." French program: Address on "The Profession" Forum on Industrial Nursing

Saskatchewan Registered Nurses' Association

Event: Thirtieth annual meeting. Date: May 29 and 30, 1947.

Place: Hotel Saskatchewan, Regina.

Planned Operating-Room Experience for the Student Nurse

CAROL M. ADAMS

THERE has been much discussion as to the value of operating-room experience for student nurses. Advantages a student derives from a carefully planned and well-guided experience are:

- 1. Develops self-confidence through a broadened outlook.
 - 2. Increases skills.
 - 3. Stimulates interest and enthusiasm.
- 4. Gives a better understanding of the different types of operative procedure and their relation to the patient's safety and progress.
- 5. Develops an appreciation of the scientific basis for aseptic operative technique, and the application to nursing procedures in general.

Several requirements are necessary for a well-planned teaching program in this department. Within the operating-room, work is done as a group without co-operation and co-ordination all is lost. How can this group activity be made a happy and satisfying experience for all? One requirement is a well prepared leader who has the ability to stimulate enthusiasm, is blessed with physical and mental health, a good sense of humor, and with a confirmed habit of thoughtful consideration of people as persons, people as individuals. Constantly working with nurses, students, and graduates at different levels of development requires the confidence of everyone with whom she comes in contact. Ordway Tead, in his article "How to Improve Personal Supervision," says: "The most successful supervisor is on the whole the one who is most a person. The bigger the person, the better the supervisor. By a big person we mean one who has a rich nature, warm feelings, broad ideas, and a hearty eagerness for life as a whole."

Plans, policies, and procedures need to be discussed, and free exchange of ideas and participation encouraged. Much is gained from a variety of shared interests. This, in turn, promotes activity that ensures progress and stimulates growth of the group so that they become a vital part of the whole. Group decisions must be the prominent feature of a democratic unit.

A well-planned, flexible, and progressive program is essential, with good clinical experience. Operatingroom experience given in the early part of the second year has proven of exceptional value in developing nursing abilities. The knowledge and skills learned in the operating-room supplement and strengthen the student nurse's future experiences. An effective teaching program, providing for progressively increased difficulty and responsibility, can be carried out during an eight-week period, giving a varied and graduated experience. It is important that this experience be undisturbed and undivided to give the maximum results.

The organization and planning of a teaching program will of necessity vary according to the facilities, activities, and personnel in the operatingroom. A program such as is here outlined has proven satisfactory and may be adapted to various situations.

During the month preceding operating-room experience, each nurse attends an eight-hour course of lectures on such topics as anesthesia, sterilization, preparation of supplies used in the operating-room, manufacturing and care of sutures and instruments, various positions of patients, and preparation of the hands. A final examination is given and is discussed with the class.

A two-week rotation plan is strictly followed, making organized teaching in the operating-room possible. During the first two weeks' experience,

daily classes given at the beginning of the day are arranged for the new students. The head nurses alternate each two weeks in giving this instruction. The orientation program is carried on throughout the entire

eight-week period.

A definite program is planned for the new students the first day. At the initial orientation conference. each student is introduced to the physical set-up of the operating-room, to her special duties as a junior student, to special routines, techniques and procedures. This helps the student to fit into and feel a part of the operating-room organization. Each student is given a manual at the beginning of her experience which is used as a teaching aid and reference. In the manual are instructions pertaining to operating-room routines and suggestions for the solution of problems that commonly arise. The manual also contains each day's list of topics and procedures to be discussed and demonstrated by the head nurse, followed by questions, with space left for the nurse to fill in the answers. The following is a sample of the first day's work in the manual:

FIRST DAY DUTIES

Topics to be included in class discussion, demonstration, and practice periods:

- (a) Names of the members of the operating-room staff.
- (b) Number and location of each room in the operating-room suite.
- (c) Equipment in general for a completely furnished room, not including instruments.
- (d) Location of sterile linen, gloves, catgut, etc.
 - (e) Location of fire extinguishers.
- (f) The immediate pre-operative and post-operative care of the patient in the operating-room.
- (g) Adjusting of overhead lights and spot lights.
- (h) Adjusting operating-room tables and positions of patient for various operations.
- (i) The anesthetic table and care of equipment.

QUESTIONS AND EXERCISES

 Describe fully the preparation of the patient in the anesthetic room before operation.

- 2. Describe fully the care of the patient when operation is completed, and before patient is returned to the ward.
- 3. Discuss the importance of good house-keeping in the operating-room.
- 4. Sterilizers: (a) Rules for operating high pressure autoclave; (b) rules for operating water-tank.
- 5. Care of anesthetic equipment—duties performed after equipment is used: (1) Magill tubes; (2) rubber airways; (3) anesthetic table; (4) mask and tubing belonging to the machine; (5) laryngoscope; (6) metal ether mask.
- 6. Miscellaneous specific observations made from the students' stand. List at least eight, (e.g., noted that circulating nurse never allowed discarded sponges, pieces of paper, etc., to lie on the floor).

Each manual is carefully checked by the head nurse daily and the student is given an opportunity to discuss any point that does not seem to be clear. This method of teaching is uniform and standard, enabling each head nurse to be familiar with what is taught and making it easier for her to carry out the necessary follow-up and guidance which is so valuable for each student. Following the orientation conference each student observes an operation from a viewing-stand and, again, is expected to write down eight specific observations made, noting especially the various procedures in which the nurses are engaged. Confidence is gained and a better picture of the whole situation is obtained from this observation period.

At the end of the first two weeks, class instruction is given on the duties and the procedures to be carried out by the junior scrub nurse. A review of sutures, draping, and instruction on sponges and assisting the senior scrub nurse is presented. The group is also taught how to completely set up the operating-room

with sterile supplies.

A discussion of the value of Lane's or bone technique, and demonstration of its use is given to the group at the end of the third week's experience.

Before starting the fifth week's experience a demonstration of senior

scrubbing is given. To make an operation realistic to the students, a mock operation is undertaken. Draping is applied, and the instrument table placed over the imaginary patient. Assignment as senior scrub nurse is made for each pupil in turn, following demonstration by the instructor. Other members of the group act as surgeon and assistant surgeon. Deftness in handing instruments and sutures to the surgeon is co-ordinated with alacrity in thinking.

The seventh and eighth weeks in the operating-room incorporate the senior duties, and the class preceding this term stresses the importance of taking responsibilities, maintaining standards, and assisting in teaching and guiding the oncoming students.

A select library in the operatingroom, with a few well chosen references, is of inestimable value to both student nurses and graduates. Alexander's "Operating Room Technique" has proven especially helpful and "Atlas of Surgical Operations," by Cutler and Zollinger, although written for the interne, is very useful.

Continuous development requires constant guidance and supervision, as individuals differ in mental and physical capacities and reactions. That the student may evaluate her own progress, a conference is held with her at the end of the first month, discussing her strengths and where she needs further strengthening, giving specific suggestions and examples characteristic of her work. Greater progress can thus be made before the student is finally evaluated at the termination of her operating-room experience.

A program such as is described above may seem complicated and not adaptable to a small school, but it is practical and, if started in a small way, may be built up and added to when possible. The unity that results from working together prevents friction, unhappiness, and dissatisfaction, and a staff that co-operates for a common goal accomplishes its work with a minimum of effort, time, and discontent.

Consultation Vans for Infants

One of the most serious consequences of the long period of restriction imposed on France by the war and occupation was the increase of infant mortality throughout the country. The French Red Cross is considering, in agreement with the Ministry of Health, a scheme of consultation vans which would travel through the communes and reach the rural population where the evil is just as serious as in the towns and more difficult to relieve. The medical and social services are short of staff and means of transport and can reach the infants in the rural districts but too rarely.

The war material of the French Red Cross was reduced and worn out by so much exhausting work; it has been renewed, thanks to the allied Red Crosses, and although it is now of uneven quality it is nevertheless possible to continue the work. The first formula consisted in using large lorries given by the American Red Cross. These lorries are now being arranged and divided into two compartments for use as consultation rooms.

The first compartment has a bench, three folding cots, two lavatories with wash-basins, a paraffin stove with three burners for heating the room and the water, and a scale for weighing babies. Some lorries also have an extensible chair for prenatal examination. The infant is undressed, washed, and weighed in this room in preparation for the second compartment which is the doctor's consultation room with all the necessary fittings.

These cars are placed at the disposal of the departments; the costs are provided by the public health and social welfare services. They are driven by Red Cross women drivers who have received a medico-social training enabling them to give efficient help to the doctor and his staff during the consultations.

This service may be considered as a very valuable contribution to the maternity and child welfare work in rural districts in France. It is hoped that it will become largely generalized, particularly in the most sparsely populated areas.

- League of Red Cross Societies.

AUX INFIRMIÈRES CANADIENNES-FRANCAISES

L'Aide ou Auxiliaire en Manitoba

FRANCES WAUGH

TE VEUX vous transmettre des renseignements que je vous apporte du Manitoba sur la licence et la préparation de l'aide ou auxiliaire. Je diviserai mon travail en quatre points: l'histoire, la loi, notre expérience, et

le diagnostique.

L'histoire: Quand le registre des médecins et des infirmières, l'ancien registre des infirmières de Winnipeg, fut réorganisé en 1921, des auxiliaires ou aides, ayant reçu au moins six mois d'entraînement, furent enrollées sur le registre pour faire du service à domicile. Quelques-unes d'entre elles avaient suivi un cours dans les sanatoria, d'autres étaient diplômées d'une maternité ou d'un hôpital d'aliénés, et d'autres avaient quitté l'école d'infirmières avant d'avoir terminé leur cours. La registraire leur donna des cas selon leur compétence et elles reçurent une rémunération qui fut déterminée par le comité de direction du registre.

Au début de 1944, une délégation de ces aides rencontra le comité de direction du registre et demanda à être payées 35 cents de l'heure au lieu de 25 cents, disant qu'il y avait des personnes n'ayant aucun entraînement et très peu d'expérience qui recevaient plus que celles inscrites au registre. La révélation de ce fait décida les auxiliaires à tenter d'évaluer les services qu'elles rendaient et elles en vinrent à la conclusion qu'il fallait qu'elles aient un programme d'entraînement et des règlements pour leur travail. La première chose qu'elles firent fut d'organiser l'Association des Aides (practical nurse). Elles

demandèrent l'assistance d'autres groupes, union ouvrière, et l'Association des Infirmières Enregistrées du Manitoba.

L'Association des Infirmières Enregistrées conseilla aux aides de demander au Ministère de la Santé et du Bien-Etre de présenter une loi les concernant et de préparer un mémoire pour le ministre. Ce conseil fut accepté par les aides et une délégation se présenta au Sous-Ministre de la Santé.

La demande des aides fut bien accueillie par le Ministère de la Santé et du Bien-Etre. Un comité fut nommé immédiatement pour préparer un

projet de loi.

Ce comité était composé d'un représentant de l'Association des Hôpitaux du Manitoba, de la Société Médicale du Manitoba, de deux membres de l'Association des G.M.E., de deux de l'Association des Aides.

Plusieurs lois furent présentées comme exemple. Le projet final fut préparé par un comité de législation. Un mémoire fut préparé et présenté au parlement avec le projet de loi. Voici quelques points importants de ce mémoire:

- 1. Quelque sort la fortune d'un malade, les soins d'une infimière doivent lui être donnés lorsqu'il en a besoin.
- 2. Lorsqu'on analyse les services rendus aux malades l'on constate que certains d'entre eux peuvent être rendus par une aide sans qu'il y ait danger pour le patient.
- 3. Le but de cette loi n'est pas d'enlever aux auxiliaires leurs moyens d'existence. mais plutôt de les mettre en mesure de rendre service là où elles peuvent le faire.

1111, 191;

Le ministère en recommandant cette loi avait en vue de:

- 1. Donner à l'aide qualifiée un status légal reconnaissant par là les services qu'elle rend et du fait protéger ses intérêts en empêchant la concurrence de personnes non qualifiées soignant les malades pour un salaire.
- 2. Mettre à la disposition du malade, lorsqu'une infirmière professionnelle n'est plus nécessaire, mais qui ne peut être laissé entre les mains d'une personne incompétente, une personne qualifiée capable de rendre service.
- 3. Permettre à une personne d'executer le travail, qui demande moins de compétence mais prend beaucoup de temps, dans les soins à donner aux convalescents, aux malades chroniques dans les institutions ou à domicile, et ainsi permettre aux infirmières professionnelles de consacrer tout leur temps aux gravement malades.

La loi fut sanctionnée le 23 mars 1945. Elle est administrée par:

- 1. Un conseil composé comme suit: Président, nommé par le ministre; 1 membre, nommé par le Bureau des Gouverneurs de l'Université du Manitoba; 2 membres, nommés par l'Association des Infirmières Enregistrées du Manitoba, l'une d'elles doit être une institutrice: 1 membre, nommé par le Conseil des Hôpitaux; 2 membres, nommés par l'Association des Hôpitaux du Manitoba; 3 membres, nommés par l'Association des Aides (practical nurse). Membres ex-officio: Le Sous-Ministre de la Santé, la directrice des Infirmières Hygiénistes Provinciales, la régistraire et conseillère des aides.
- 2. Un bureau de direction formé par sept membres du conseil dont les devoirs sont déterminés par la loi.
- 3. Des comités spéciaux ont dû être nommés pour faciliter l'administration de la loi, les voici:
- (a) Le comité du programme d'étude qui est chargé de préparer le programme d'étude pour les aides. Ces mêmes personnes font aussi partie du comité des examinateurs chargé de corriger les examens et de marquer les points.
- (b) Le comité de créance formé de quatre membres étudiant toutes les demandes de licence; ce comité continuera à examiner les

qualifications des aides demandant le droit de pratique par réciprocité et les qualifications des personnes désirant suivre le cours.

- 4. La nomination d'une régistraire et consultante, une infirmière enregistrée, dont les devoirs sont:
- (a) Recevoir toutes celles qui demandent une licence pour exercer comme aide licenciée et examiner les qualifications de chacune.
- (b) Ménager des entrevues aux aides et les aviser.
- (c) Surveiller le tours de toutes les aides dans la province.

(d) Tenir un registre de toutes les aides de

la province.

5. Avec l'approbation du ministère établir une école centrale pour la formation des élèves. La partie théorique du cours, institutrices, matériel d'enseignement, seraient à la charge du ministère et l'expérience clinique serait fourni par les hôpitaux.

6. Avec l'approbation du ministre, faire avec une institution, les arrangements nécessaires pour l'entraînement

au complet des aides.

Expérience: A l'une des premières assemblées du comité des aviseurs, l'Association des Hôpitaux du Manitoba et l'Association des Aides recommendèrent l'adoption d'un tarif suivant, qui fut approuvé par un ordre en conseil:

8 heures de service, \$3.60;10 heures de service, \$4.00; 4 heures de service le soir, \$2.00; temps supplémentaire, 45 cents de l'heure.

Les auxiliaires furent averties par différents moyens de publicité qu'elles devaient se procurer une licence avant le 31 décembre 1946 si elles voulaient être acceptées sous la clause d'exemp-

tion (waiver clause).

Pour obtenir leur licence elles doivent remplir une formule donnant diverses informations, entre autres, l'institution où elles ont reçu leur formation ou acquis de l'expérience, le nom d'un médecin et d'une infirmière professionnelle pouvant témoigner de leur compétence. Une entrevue avec la régistraire est aussi nécessaire. Si les renseignements sont satisfaisants et approuvés par le comité de créance et le conseil, l'aide reçoit une licence puis une carte d'identification et une épingle qui

doivent être renouvelés annuellement.

La licence est de cinq dollars et son renouvellement annuel un dollar. Deux cours de perfectionnement furent donnés en 1946 pour les personnes qui n'avaient pas les qualifications nécessaires. Des stages dans les hôpitaux durent être faits par quelques-unes qui avaient besoin de plus d'expérience.

Les six cents personnes que j'ai vu à mon bureau peuvent se classifier

comme suit:

(a) Très peu d'expérience, aucune instruction; (b) plusieurs années d'expérience, aucune instruction; (c) n'ayant suivi que le cours de l'Ambulance St-Jean ou de La Croix-Rouge; (d) des vétérans ayant eu de l'expérience dans les hôpitaux; (e) des diplômées de maternité, d'hôpitaux d'aliénés ou de sanatoria; (f) des élèves n'ayant pas terminé leur cours d'infirmière; (g) des infirmières diplômées non-enregistrées.

Environ quarante suivirent les cours de perfectionnement. A date 418 ont reçu une licence. L'on conseilla à celles qui furent refusées de suivre le cours en entier. Le règlement concernant le travail des aides a été préparé mais n'est pas encore officiel.

En janvier 1946, les premières classes, conformément aux dispositions de la loi, furent acceptées. L'une, à l'école centrale, trois petits hôpitaux (n'ayant pas d'école d'infirmières) donnèrent l'expérience clinique. Une infirmière en hygiène publique fut nommée institutrice; elle fut aidée par la diététicienne du Ministère de la Santé. L'autre classe fut acceptée au Sanatorium de St-Boniface, affiliation avec l'Hôpital Ste-Rose.

Le cours consiste en trois mois de théorie et neuf mois d'expérience clinique. A date l'expérience n'est donnée que dans les hôpitaux et sanatoria. Nous espérons sous peu être en mesure de donner aux aides une expérience à domicile. Voici ce qui est exigé pour l'admission au

cours d'aide:

(a) Le 8e année du cours d'étude; (b) un certificat de bonne santé; con si l'étudiante

n'a pas 21 ans lorsqu'elle termine son cours, elle ne reçoit pas sa licence avant d'être majeure; durant cet intervalle elle doit être sous la surveillance immédiate d'une infirmière enregistrée.

Depuis l'ouverture de la première classe, l'école centrale dirige des cours pour six hôpitaux; quatre institutions ont leurs propres écoles.

Une enquête faite en décembre révélait qu'il manquait 250 aides dans les institutions. Une lettre a été adressée à toutes les institutions d'hospitalisation, les avisant que les personnes n'ayant pas de licence ne peuvent être employées que comme bonne ou aide de salle, et jusqu'à nouvel avis de la règlementation du travail, la directrice du personnel ne devait leur confier que le travail qu'elles peuvent accomplir.

Diagnostic: D'après mon expérience

de l'an dernier je désirerais:

1. Que toutes les auxiliaires qui demandent une licence et qui n'ont jamais reçu d'entraînement (a) passent un examen; (b) qu'elles aient

quatre ans d'expérience.

- 2. Qu'on se rappelle, qu'un des buts de la loi est de placer l'aide selon sa compétence, nous devons examiner avec soin tout le travail de l'infirmière afin de déterminer ce qui convient aux aides. Dans notre province nous n'avons pas suffisamment de personnel dans les campagnes pour soigner les malades. Nos étudiantes ne sont pas préparées pour faire du travail d'hygiéniste. Nous ne voulons donc pas, à moins que ce soit à titre d'expérience, placer nos aides dans les unités sanitaires du moins jusqu'à ce que l'organisation et la surveillance du service auprès des malades dans les hôpitaux et à domicile soit complétées.
- 3. Que l'expérience clinique soit donnée dans les salles de malades et

à domicile.

4. Qu'il y ait un intervalle de temps suffisant entre chaque classe pour permettre à l'institutrice de continuer l'enseignement dans les salles de malades.

Strained orange juice has lost some of its vitamin C content which is normally contained in the pulp.

Interesting People

Alexandra MacKinnon Munn, who, since 1924, has directed the activities connected with the Nurse Registration Branch of the Department of Health for the Province of Ontario, has retired. Born in Coningsby, Ont., of Scottish and English parentage, Miss Munn graduated in 1913 from the Stratford (Ont.) General Hospital, winning the medal given for general proficiency. After a brief period of post-graduate study and experience in the United States, she returned to her alma mater as assistant superintendent of nurses, assuming the superintendency in 1918.

Through these intervening years, Miss Munn has exerted a powerful influence on nursing and nursing education. The provisions of the Ontario Registration of Nurses' Act were carried out under her jurisdiction. These included the regular inspection of all schools of nursing in the province as well as the responsibility of examining, regulating, and registering the members of the nursing profession. There has always been the closest co-operation between the provincial nurses' association and Miss Munn's department.

Imbued with high ideals for public service, and a staunch supporter of the nursing profession's best tradition, Miss Munn was ever willing to give of her wise counsel and rich experience. Kindly, cheerful, possessed of an unusual degree of charm and an all-saving sense of humor, hers is indeed a generous and mellow personality. Those coming in contact with her have benefitted from her great

capability, her strength of character, her broad and deep understanding. Now, in her retirement, Miss Munn will have the time and opportunity to enjoy her much loved books, music and pictures, and, especially, to care for her garden.

Anne Wright was honored by the Board of Governors and staff of the St. Catharines General Hospital, Ont., on the occasion of the twentieth anniversary of her appointment as superintendent. Among other gifts made to her at this time was a silver tray and tea service.

Born in Galt, Ont., Miss Wright secured her teacher's certificate in 1909. After a few years in the teaching profession, she entered the Toronto General Hospital School for Nurses and graduated in 1919. She joined the T.G.H. staff as operating-room supervisor, advancing to second assistant superintendent of nurses in 1921. In 1925, she became assistant superintendent of nurses at the Victoria Hospital, London, Ont. From there she went to St. Catharines in 1927. Miss Wright served as chairman of District 4, R.N.A.O., for a two-year period.

A member of the St. Catharines Golf Club and the Business and Professional Women's Club, Miss Wright has always taken a helpful interest in community welfare activities. She served for seven years on the Y.W.C.A. Board in St. Catharines.

We join her associates in congratulating



Leatherdale, Toronto
ALEXANDRA MUNN



ANNE WRIGHT

Miss Wright and wishing her well in her work.

Priscilla Campbell recently celebrated her twenty-fifth anniversary as administrator of the Chatham Public General Hospital, Ont. In honor of the occasion, Miss Campbell was presented with a chest of silver at a testimonial dinner. Miss Campbell's election as president of the Ontario Hospital Association was noted on this page in the January, 1947, issue.

Vera E. Hayden was named assistant superintendent of the Kootenay Lake General Hospital in Nelson, B.C. In 1929, Miss Hayden graduated from the school of nursing of the K.L.G.H. She engaged in private and general duty for seven years before accepting a position as floor supervisor in her home school. Her varied experience there has given her an intimate knowledge of all aspects of the hospital's activities.

On April 6, 1947, Agnes Douglas Carson, the grand old lady of nursing in New Brunswick, retired from active duty after nursing for over half a century. Born in St. Andrews, N.B., on February 23, 1867, Miss Carson matriculated from the Charlotte County Grammar School in 1891. In November of 1892 she entered the Saint John General Hospital, then known as the General Public, as a probationer. At that time, the course of training was two years in length. graduation, Miss Carson undertook district nursing in Saint John at the splendidly generous salary of \$175 a year! In December, 1895, she went as a staff nurse to the New York Polyclinic Medical School and Hospital, becoming superintendent of nurses in 1896. She organized post-graduate courses for nurses there the following year.

In 1913, Miss Carson resigned from this position in order to go to Detroit to serve as organizer and superintendent of the Detroit Home Nursing Association. After nine years in that field of activity, Miss Carson returned to Canada, accepting the position of assistant



Agnes D. Carson

superintendent of nurses at the Victoria General Hospital, Halifax. Three years later she resigned from that position to become superintendent of the Hospital for Sick Children in Halifax.

Home responsibilities called her to St. Andrews in 1929. Two years later she returned to active duty on the night nursing staff of the Saint John Tuberculosis Hospital where she has been employed continuously until her recent retirement.

Through the long years, Miss Carson has been closely identified with the professional organizations of nursing in every community in which she has worked. Apart from her professional activities, she has maintained a steady interest in other aspects of community Her rich, full and useful life endeavor. exemplifies the goal of service she set for herself so many years ago. Her guiding principle has been to live out the words: "Make no little plans. They have no magic to stir men's blood and of themselves will probably not be realized. Make big plans, aim high in hope and in work, and remember that a noble, logical aim, once recorded, will never die, but long after we are dust, will be a living thing, repeating itself with everincreasing insisten v

Preview

What is being done in the rehabilitation of the parapegic patients, especially the young veterans? Dr. G. Gingras has given us our first picture of the problem the paraplegic presents. Dr. Paul Green describes, in greater detail, some aspects of the rehabilita-

tion program. Finally, George Petrle, himself a paraplegic, and editor of the magazine published by the Canadian Paraplegic Association, *The Caliper*, tells us some of the difficulties the paraplegic has to overcome in facing up to life situations.

In Memoriam

It is with sincere regret that we record the passing of Mrs. Bedford Fenwick, the gallant old lady of ninety, who maintained her lively interest in nursing through her post as editor of the *British Journal of Nursing* until her death on March 13, 1947. Mrs. Fenwick suffered a fractured femur last summer.

Over sixty years ago, as Ethel Gordon Manson, Mrs. Fenwick was matron of St. Bartholomew's Hospital in London, England. Her qualities of leadership were evidenced early when, in 1894, she founded the Matrons' Council of Great Britain and Ireland. Under her presidency, this body grew and after many successful Congresses in Britain, other countries were encouraged to form similar bodies. Mrs. Bedford Fenwick had the vision of an International Council of Nurses and, as its founder and first president, initiated this body in 1900, the first international organization of professional workers in the world.

"Just and due honor cannot be paid to so great a national nursing figure within the small confines of an editorial; the thrilling adventures of such a full and useful life can only be found in the absorbing pages of a biography." Her name will be remembered by nurses in every country.

Dorothy M. Barton, who graduated in 1920 from the Nova Scotia Hospital, Dartmouth, died recently. At the time of her death Miss Barton was assistant matron of the Prince Albert Sanatorium, where she had been on the staff for seventeen years.

Elsie Maude (Bickell) Brown, a graduate with the class of 1894, from the Montreal General Hospital, died in Montreal early in March.

Maud Carter, one of the first graduates of the Charlottetown Hospital, P.E.I., died recently in Worcester, Mass.

Marie Francy, who had served on the staff of the Nova Scotia Sanatorium for the past two years and previously had nursed in the United States, died recently in Kentville, N.S.

Lena Graham, who graduated from the

Utica (N.Y.) General Hospital, died suddenly at her family home in Napanee, Ont.

Lily deVeer Hall, who graduated from the Toronto General Hospital in 1926, died at Wakefield, England.

Anne Charlotte Henderson, a native of Brantford, Ont., died recently in Toronto. Miss Henderson had engaged in private duty nursing for more than forty years, retiring in 1944.

Kathleen (Twiss) Howitt, who graduated in 1925 from the Toronto General Hospital, died at Preston, Ont.

Theresa Hushin, a graduate of St. Joseph's Hospital, Toronto, in 1925, died recently in Toronto. Miss Hushin organized the central service department of St. Joseph's Hospital and had been on the staff there for nineteen years.

Thyra B. Jordan, a member of the class of 1907 of the Toronto General Hospital, died in Toronto. Miss Jordan did private duty nursing for a few years and then entered into public health nursing with the Toronto Department of Public Health. She had retired three years ago.

Lucy (Dunlop) Kane, a graduate of the Ottawa General Hospital in 1940, died suddenly in Ottawa following an operation.

Kate (Johnson) Kerr, who graduated from the Toronto General Hospital in 1891, died in Toronto.

Etta Naomi Lane died in Saint John N.B. After completing her course in music at Mount Allison University, Sackville, N.B., Miss Lane taught music for some time before entering the school of nursing of the Bridgeport (Conn.) Hospital. After practising general nursing for a few years, Miss Lane became matron of the Fisher Memorial Hospital, Woodstock, N.B., and served there for thirteen years. In 1922, Miss Lane went to New York to work, retiring in 1927.

Idella Gertrude MacGregor, who had

heen associated with the Victorian Order of Nurses in Ottawa for many years and who served as a nursing sister in World War I, died recently in Vancouver.

Lucy Marguerite Morin, of the class of 1918 of the Toronto General Hospital, passed away in Toronto.

Mary Margaret Shearman, a nursing sister in World War II, died suddenly at the Cornwallis (N.S.) Veterans Hospital.

Adelaide Sims, who graduated from the, Royal Victoria Hospital, Montreal, in 1898 died in Ottawa in her eightieth year. After several years in nursing, Miss Sims returned to R.V.H. as night superintendent. She served in this capacity for many years then

went to the United States where she held positions as superintendent in several hospitals. She retired five years ago.

Catherine Frances Spence, a native of Toronto who graduated from St. Luke's Hospital, Chicago, and served as a nursing sister with the American Army Nurse Corps during World War I, died recently in Toronto in her seventy-seventh year.

Kathleen Mary Stanton, a graduate in 1937 from the Royal Victoria Hospital, Montreal, died suddenly on March 20, 1947, at the age of thirty-two. Following graduation Miss Stanton joined the teaching staff at R.V.H. In 1943 she was appointed to the faculty of the McGill School for Graduate Nurses.

Cardex System for Nurses' Orders

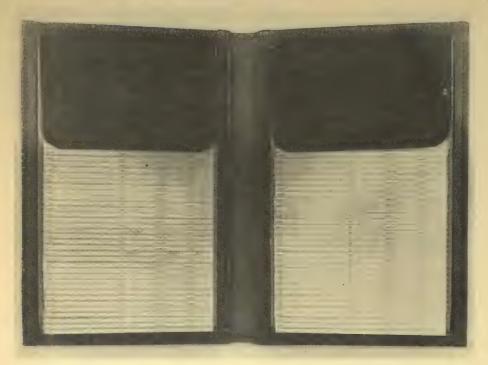
ISABEL RICHARDSON and CATHERINE MACLEOD

PATIENTS' records are constantly becoming a more time-consuming part of the ward program, due largely to the steady increase in the administration of drugs and other therapy, all the recording of which passes to the nurses.

The part of this responsibility which matters greatly is the method by which the records are clearly passed on to others in the changing nursing personnel of a mere twenty-four hours.

For accuracy and quick reference the following Cardex System is being

#127 tours				
AY ORDER		NHOL TRIAS		
TEST PATE		TREATMENTS	MED: AT N	DIET
	-			
-				
	-			
- C.S. C.S.				
-	1-			
		1		
10 THOIS	ene			
-				
	-			
- 1				
		1		
-				
-				
-				
AME		to:	C-M 30 A.)	ROOM



used at the Saint John General Hospital. After approximately eighteen months' trial it is felt that this system has considerably lessened the time spent on ward-bookkeeping, promoted the relaying of information from nurse to nurse, and has prevented unnecessary repetition and writing.

The Cardex is similar to that found in any business office. The card folder is leather-covered, fourteen by ten inches, keeping in place thirty-three card-holders, each with a plastic transparent covered lower edge into which fit the individual cards, placed one behind the other. The arrangement could be in any sequence, such as alphabetically, according to room numbers, diagnosis, doctors, etc. The individual card, which is reversible, has fifteen lines for day orders and nine for night orders on each side. Three vertical lines divide the card into three narrow and one wide column which are headed as follows: date started: date discontinued; time, for the narrow columns; treatment, medication, and diet, for the wide column. At the bottom of each card there is a line for the name of the patient and doctor, the case and room numbers, which are all visible through the transparent plastic. The Cardex is kept at the supervisor's or charting desk where it is accessible to all.

The difference between the Cardex cards and the order sheet of a chart is that the chart sheet contains all orders given by the doctor since admission of the patient, while the Cardex record contains present treatments only; the date an order is discontinued is recorded in that column and a line drawn through the order as an added precaution. When recopying the cards all previously cancelled orders are omitted, consequently one card provides room for all orders. To prevent the card becoming filled too quickly, all orders which are to last for a day or less such as blood chemistry, basal metabolism rate, etc., are written on medicine cards and placed in the holder with the patient's card.

In addition to the cards, a report called a Day Book is kept.

(Please turn to page 386)

Notes from National Office

International Visitors

The Canadian Nurses' Association extends a warm welcome to all international visitors who will be guests at the I.C.N. Congress in Atlantic City, N.J., May 11-16.

Student or Employee

The following commentary was published in the February 15, 1947, issue of *Nursing Times*. It provides much food for thought in our Canadian scene:

The Lancet suggested some time ago that all nurses should have a uniform two years' training—whether they were of the type suitable to train as assistant nurses only or able to qualify for State registration. Now it suggests that the plight of London County Council, and other municipal hospitals which are so short of nurses that wards must be closed, is the fault of the policy of the Rushcliffe Committee which has laid down uniform national salary scales for all student nurses, Previously, local authorities who had difficulty in obtaining candidates for training could attract girls, who had particular need for financial help, by offering more attractive salaries. Now all schools offer the same increased salaries.

What has been the result? The London County Council hospital service is reduced to less than half its pre-war complement of beds in spite of the fact that the number of nurses entering for the State examinations and qualifying has risen steadily; the majority of the large teaching hospitals have been able to increase their staffs to permit the reduction of hours (96-hour fortnight). Some are also trying to introduce the block system of training or the weekly study day which necessitates more candidates to maintain the ward staffs.

In the days before the Rushcliffe Scales were introduced the more popular training schools could offer modern buildings, firstclass teaching and nursing equipment, had a reputation for making the student nurses happy, and often charged fees for the preliminary period, and paid comparatively low salary scales during training, yet these schools had long waiting lists because of their standing in the nursing and medical worlds. Other hospitals with less pleasant situations and less famous names could attract a moderate proportion of candidates by offering definitely higher salary scales. Now salaries are the same throughout.

The London County Council has met many of the points that are raised by the general public as main causes of the unpopularity of nursing, e.g., off duty restrictions, official hours of duty, etc. Whether nurse training schools, which have concentrated on improving the training and making it more sound educationally rather than doing everything possible to make life easier, have not chosen the wiser course is a question which these facts may partly answer.

The Lancet suggests that student nurses shall have a salary of £100 a year for each of their three years of training (£55 now being received).

The Student Nurses' Association has discussed the matter and many individual nurses have stated that they thought that better opportunities for learning and shorter hours on duty were much more urgent matters than increased salaries. They have appeared to realize that the more money they receive the more they become employees like the domestic and maintenance staff and the less they can expect in the way of educational facilities.

Those who think the paying of higher salaries the better way to attract suitable recruits imply that the student nurse says this because she knows it is expected of her and will please those in authority over her. The modern girl is not, in our opinion, so lacking in independent thought as her detractors would make her. She thinks for herself and says what she thinks. Good educational facilities make her work interesting and satisfying. The better her training the more she

MAY 1947

P

understands and enjoys her work. If the ward sister is a sympathetic, keen teacher and senior colleague rather than her "boss," it makes all the difference to her enjoyment of her training. These things count with the average student nurse more than pounds, shillings and pence. The more her work and status approach to that of the physiotherapy student and medical student, the less will be the shortage of entrants into a profession which can be both intellectually and emotionally satisfying to a large number of young women with a considerable range of intellectual capacity.

On the other hand, it seems easier to give a little extra money to each nurse than to take time for the planning and the carrying out of the program necessary to obtain a good team of nurse, medical, and allied teachers, who will give the capable girl interested in nursing the professional training which will ensure intelligent nursing care for the sick who need it.

Questionnaire

In an endeavor to determine how it can be of further service to the nurses of Canada, the Canadian Nurses' Association is seeking information from individual nurses, through their local units of the provincial associations.

The Executive Committee of the Canadian Nurses' Association endorsed the request of the president. Miss Chittick, that a questionnaire soliciting opinions should be formulated for the guidance of nurses in submitting their suggestions. National Office staff has prepared this questionnaire which is designed to assist nurses in making suggestions as to their professional needs. When these questionnaires have been completed the information will be compiled and will serve as a guide in planning for travelling institutes or refresher courses, and also in planning the program for future conventions. Every effort will be made to meet the requests of the majority opinion of nurses.

It is hoped that every member of the C.N.A. will play her part in completing the questionnaire and returning it, as early as possible, to National Office.

CANADIAN NURSES' ASSOCIATION Questionnaire

ro	vince
	trict Chapter and/or Alumnae
	Do you believe that a travelling institute or refresher course would be of value?
	Would any of the following suggested topics be suitable or desirable? If so, please check:
	(1) Public Relations: Methods and Functions of Public Relations Groups:
	a. Personnel Policies and Practices
	b. Personnel Management
	(2) Selection of Personnel—Staff and Students
	Tests and Measurements
	(3) Vocational and Guidance Programs
	(4) Methods of Teaching:
	a. Films and other visual aids
	b. Group and individual techniques
	c. Supervisory techniques
	d. Staff conferences
	(Methods of conducting)
	(5) Extra-Curricular Activities:
	a. Hobbies—handicrafts
	b. Creative writing

	c. Music and drama
	d. Public speaking
	e. Organization of clubs
	f. Current events
	g. Personality development
	h. Personal and social problems
	i. Others
3.	What topics would appeal most directly to the following? (List topics in order of
	preference.)
	Institutional Nurses:
	(a) Superintendent of Nurses
	(b) Superintendent of Hospital
	(c) Instructors in Schools of Nursing
	(d) Supervisors in Schools of Nursing
	(e) Supervisors (state special field)
	(f) Head Nurses
	(g) Assistant Head Nurses
	(h) Staff Nurses (general duty) (state special field)
	(i) Nurses in Special Hospitals, e.g., chronic, convalescent, aged
	Public Health Nurses:
	(a) Director of Nurses
	(b) Supervisors
	(c) Staff Nurses
	Industrial Nurses:
	Private Duty Nurses:
	Other Groups:
	What other topics or courses would you like to include?
	General Topics:
	Specific Topics:
	What time would be most satisfactory for your community? Please check.
	(a) All day
	(b) Afternoons and evenings.
	(c) Evenings only
5.	How large a group of nurses might be expected to enrol for such a course in your
	community?
7.	Would a combination of local groups be possible or practicable in your area?
	What accommodation is available for a series of lectures and or demonstrations?
)	What rental, if any, would be required for such accommodation?
7.	Should a registration fee be charged to help defray expenses?

11. Other suggestions or comments from your group:.....

DATA ON STUDENT NURSE ENROLMENT IN SCHOOLS OF NURSING IN CANADA for the year ending December 31, 1946—with comparative totals only for 1945.

	First Year		Second	Third		Number to
Province	Proba- tioners	Juniors	Year	Year	Total	Graduate in 1947
Alberta	299	163	313	303	1,078	297
British Columbia	141	234	300	351	1,026	309
Manitoba	198	220	298	226	942	213
New Brunswick	207	101	190	194	692	193
Nova Scotia	186	157	255	217	815	220
Ontario	1,044	613	1,253	1,413	4,323	1,378
Prince Edward Island	40	27	32	39	138	39
Quebec: English	184	103	267	239	793	239
French	442	380	578	589	1,979	587
Saskatchewan	161	260	349	302	1,072	298
1946 Totals	2,902	2,258	3,835	3,873	12,858	3,773
1945 Totals	2,083	2,453	3,871	3,744	12,151	in 1946 3,598

Notes du Secrétariat de l'A.I.C.

Aux Visiteuses Internationales

L'Association des Infirmières du Canada souhaite la plus cordiale bienvenue aux visiteuses internationales qui seront les invitées du Conseil International des Infirmières lors du congrès qui aura lieu à Atlantic City, du 11 au 16 mai.

DES ETUDIANTES OU DES EMPLOYEES?

Sous ce titre le *Nursing Times*, journal officiel du Collège Royal des Infirmières de Grande-Bretagne, fait des commentaires susceptibles d'intéresser vivement les infirmières canadiennes. Le Collège Royal

des Infirmières correspond à notre association nationale; il n'y a pas d'associations provinciales. L'Association des Etudiantes dont il est question est une association cadette du Collège Royal des Infirmières.

The Lancet est une des plus anciennes revues médicales d'Angleterre. "The Rushcliffe Committee" est un comité chargé un peu avant la guerre de faire une étude approfondie des conditions de travail des infirmières, etc. Ce comité a fait des recommandations qui ont été imposées à tous les hôpitaux. "The London County Council" est un corps

administratif. Des sommes considérables provenant des taxes sont employées à ériger, à maintenir des hôpitaux généraux et spéciaux, sanatoria, autres institutions, etc. "The London County Council" administre cet argent et ces institutions.

The Lancet suggérait, il y a quelque temps, que toutes les élèves infirmières, qu'elles aient les qualifications pour être admises aux examens d'enregistrement ou qu'elles n'aient que les qualifications pour devenir aides, suivent le même cours pendant deux ans. Maintenant le même journal dit que c'est la faute du "Rushcliffe Committee" si "The London County Council" et d'autres hôpitaux municipaux se trouvent en si mauvaise posture. Ces hôpitaux ont dû fermer des salles faute d'infirmières. La politique du comité Rushcliffe a été de recommander une rémunération uniforme pour toutes les étudiantes infirmières du pays.

Avant que cette échelle desalaires uniformes soit adoptée, dans certains hôpitaux où le recrutement était difficile, l'administration locale réussissait à attirer des candidates peu fortunées, en leur offrant une rémunération plus élevée que celle donnée dans d'autres écoles. Maintenant toutes les écoles doivent offrir la même rémunération.

Quel a été le résultat de cet uniformité? "The London County Council" ne peut offrir aux malades que la moitié des lits dont il dispose, faute d'infirmières, bien que le nombre d'infirmières diplômées se présentant aux examens de l'Etat (équivalente de la licence dans P.Q.) ait augmenté constamment. La majorité des hôpitaux ayant de grandes écoles d'infirmières ont été capable d'augmenter suffisamment leur personnel pour permettre de diminuer les heures de travail (96 heures par quinzaine).

Dans quelques écoles l'on essaie d'introduire l'enseignement périodique (blocsystème) ou la journée d'étude hebdomadaire (voir Canadian Nurse, fév. 1947, p. 141). Tout celà veut dire plus de personnel à l'hôpital.

Même avant que l'échelle de salaires Rushcliffe fut adoptée, les écoles d'infirmières les plus populaires étaient celles qui pouvaient offrir un logement moderne, un enseignement supérieur, et des facilités de travail. Ces écoles avaient la réputation de rendre les élèves heureuses. Souvent ces écoles demandaient à leurs élèves une contribution pour les premiers mois du cours et donnaient une très légère rémunération durant les trois années

de formation; tout de même ces écoles avaient de longues listes de candidates, la réputation de ces écoles étaient connue aussi bien par les infirmières que par les médecins.

Comme nous l'avons déjà dit d'autres hôpitaux qui étaient dans une situation moins enviable pouvaient attirer une certaine proportion des candidates à l'étude de la profession en leur offrant définitivement un salaire plus élevé. Maintenant les rémunérations sont les mêmes partout.

"The London County Council" a fait des concessions sur des points, qui au dire du public sont les causes de l'impopularité de la profession—par exemple, on a enlevé certaines restrictions lorsque l'élève n'est par en service, des heures de travail déterminées, etc.

Il reste à savoir quelles sont les écoles qui ont adopté la ligne de conduite la plus sage: celles qui ont mis tous leurs efforts pour améliorer le cours d'infirmières en considérant d'abord le côté éducation ou celles qui ont fait en leur pourvoir pour rendre la vie plus facile.

Les faits suivants semblent vouloir répondre à cette question. The Lancet suggère que chaque élève infirmière reçoive un salaire de £100 (\$420) par année durant les trois années du cours (elles reçoivent actuellement £55).

L'Association des Elèves Infirmières ont discuté cette question et un grand nombre d'infirmières ont tenu à donner leur opinion personnelle. Elles considèrent que: assurer des facilités d'éducation et des heures moins longues de travail sont des choses beaucoup plus urgentes que d'augmenter les rémunérations aux étudiantes. Ces élèves semblent réaliser que lorsqu'elles reçoivent plus d'argent, elles sont considérées comme des employées au même titre que le personnel chargé de la surveillance ou du personnel domestique et elles peuvent s'attendre à moins au point de vue enseignement.

Ceux qui croient qu'un salaire plus élevé pour les écoles d'infirmières serait un moyen d'attirer plus d'élèves, supposent que les élèves qui se sont prononcées contre ce projet l'ont fait pour plaire aux autorités dont elles dépendent et que cette réponse était attendue. La jeune fille moderne, selon notre opinion, a plus d'indépendance de jugement que ces gens veulent bien lui en attribuer. Elle pense par elle-même et dit ce qu'elle pense. Un bon enseignement lui crée de l'intérêt dans son travail et lui donne de la satisfaction.

Plus le cours est bon plus elle comprend et

aime son travail. Si l'hospitalière est une institutrice sympathique, enthousiasmée et une compagne aînée plutôt que l'autorité qui commande, celà fait toute la différence du monde pour le bonheur de l'élève durant son cours. Celà compte plus pour la moyenne des élèves que l'argent. Plus le cours de l'étudiante infirmière se rapprochera du cours de la physiothérapiste ou de l'étudiant en médecine, moins il manquera de candidates à une profession qui peut donner à un grand nombre de jeunes filles satisfaction au point de vue intelligence et émotion.

Par contre, il semble facile de donner un peu plus d'argent à chaque infirmière que de prendre le temps de préparer un programme, de le mettre à exécution afin d'avoir un bon personnel enseignant, infirmières, médecins, et autres professeurs capables de donner à une jeune fille intelligente une formation professionnelle et aussi assurer au malade les soins intelligents.

L'Association des Infirmières fait une tentative pour déterminer comment elle peut mieux rendre service aux infirmières. Elle demande des renseignements à ses membres par l'intermédiaire de groupements moins considérables que le sien.

Le Comité de Régie de l'A.I.C. appuie la demande de notre présidente, Mlle Chittick, à savoir, qu'un questionnaire soit envoyé afin de servir de guide dans les suggestions que vous soumettrez.

Lorsque ces questionnaires seront complétés, nous empilerons les informations reçues, elles nous serviront de guide pour les cours ambulants et post-scolaires et aussi pour préparer les programmes des congrès futurs.

Nous ferons toute notre possible pour répondre aux demandes générales des infirmières.

Nous espérons que chaque membre de l'A.I.C. dira son mot lorsque l'on répondra à ce questionnaire.

Cardex System for Nurses' Orders

(Continued from page 380)
In this, such information as result of treatments, temperature, pulse, respiration, general conditions of patients, admissions, etc., are briefly recorded; this is used together with the cards in giving the evening report. The night nurses in turn make a similar short summary of all clinical data of patients in a Night Book which is given by the senior night nurse to the day staff. By using the cards with these reports much repetition of writing is avoided.

When a new patient is admitted a card is made out and placed in the folder. As soon as the doctor's orders are written they are transferred to the card and chart. On discharge of the patient, the card is discarded and the space left empty.

In addition to the record of orders the Cardex System has other time-

saving values.

To the student or general duty nurse: It enables her to easily check and become familiar with the diets, treatments, and medications. By closely observing the doctors' order book all new orders are made known to her through the day; new orders are

copied on the cards as soon as possible after they have been given. When charting she has the opportunity of comparing the day or night book with the cards, thus knowing whether she has all information required before proceeding with her charting.

To the new or private duty nurse: She may easily locate patients for telephone messages, visitors, etc., through referring to the Cardex.

To the supervisor or head nurse: It provides a good reference file when making out discharge slips, transfer slips, diet sheets, etc., thus saving the time and energy of going from chart to chart getting correct data, such as case number, doctor's name, etc. The blank spaces provide an easy means of checking the position of empty beds.

From the above information it seems the system has a time-saving value in more than one situation. It has a certain amount of flexibility useful in different services where the method of ward-bookkeeping varies. Finally, it seems to fit into the present day program of any busy

ward service.

STUDENT NURSES PAGE

Toward a Better Understanding

MARGARET McCullough

Student Nurse

Toronto General Hospital School for Nurses.

In our School for Nurses, two weeks are set aside for a "Public Health" term. Each student is assigned to a definite ward where she is given the care of three patients. She makes a thorough study of each patient's history, his home life, and all factors affecting his recovery. During this term the student is especially alert to the health teaching which is essentially a part of all good nursing care. This teaching is emphasized in informal conferences with our health education instructress. Various patients are discussed, their habits, and what can be done to help them most.

In conjunction with the ward term, it is arranged for the student to "go out" with a nurse in the Public Health Department. The nurse has her work so arranged that the student spends two mornings at the school clinic, one afternoon at a Child Health Centre, and the remaining three afternoons on public health visits.

The visit which was outstanding in my experience was one to trace tuberculosis contacts. Miss R received a report that "Mrs. S was a patient on a medical ward in a general hospital, with a diagnosis of pleurisy with effusion, presumptively tuberculosis. Her mother's home must be visited to list contacts."

The home was one familiar to Miss R through school visits. She

made the visit with several things in mind:

- To list contacts and make appointments at the Gage Institute* for free chest x-rays.
- 2. To see if the family needs assistance in the event of the patient's return.
- 3. To review the conditions of the home and the ability of Mrs. M to care for her daughter.

The house as we approached it looked fairly well kept, but the interior was crowded and poorly lighted. Mrs. M greeted us with "Well, I guess you've come to see the patient; she arrived today." We followed her up a long flight of stairs to the bedroom. Mrs. S was lying chatting with a young man who was sprawled across her bed. He was later intro-duced as "the star boarder." We first entered into a discussion about blankets. Mrs. M wanted to pile blankets on the patient and open the window which put a direct draft on the bed. The room was filled with the stifling odor of coal-gas and the air was blue with cigarette smoke. Miss R suggested putting a board across the window as a draft The discussion turned deflector. to Mrs. S's stay in hospital and her version of hospital situations common to us was very amusing.

MAY, 1947

^{*}Operated by the National Sanitarium Association and the Toronto Hospital for Tuberculosis, Weston, Ont.

Very gradually Miss R arrived at the problem of contacts. Mrs. M was quite responsive, gave her the probable contacts, and assured us that the appointments would be kept faithfully.

When approached on the problem of caring for her daughter, Mrs. M was a bit doubtful about trips upstairs, bed-baths, etc. Miss R suggested the possibility of having a Victorian Order nurse or similar agency come in to help. Mrs. S had been well-informed in hospital as to her conduct at home — complete rest for two months; but to us it seemed doubtful if she would or could carry this out. To complicate matters she had a very active two-year-old son. Miss R enlisted the aid of the mother and re-emphasized the importance of complete rest and proper diet.

When Miss R asked about financial assistance, there was a difference of opinion between mother and Then Mrs. M explained daughter. the situation. Mrs. S and her husband had been separated for over a year with considerable hard feelings between them. If she asked assistance she was afraid that in subsequent investigation her husband would be contacted, and if he could prove her unable to support her son, the husband would claim custody. Miss R promised to find out about it and, if possible, arrange care through a fund available to those recovering from tuberculosis.

The visit was instructive in many ways. I found it interesting to note how many problems arose in one case, how each was tackled separately and a tentative solution found. We left the home feeling that we had accomplished much in a short visit.

Another of the interesting patients was Mr. T, a middle-aged bachelor, who was convalescing from a coronary thrombosis. Most of his health problem lay in his mental attitude. He found it very difficult to "stick"

to the coronary routine. He worried about his hospital bill. He imagined himself acquiring the symptoms of other cardiac patients, such as, shortness of breath, cyanosis, edema, etc. His eating habits were also a problem in that he disliked institutional cooking and did not like being fed.

In casual conversation I found that he had a family history of cardiac complaints. This made an ideal opening for health teaching about cardiac disease. I was able to explain why he was on coronary routine, why it was so important that he be fed, bathed, and moved. He was very interested in the different heart diseases, the symptoms, the treatments, and the necessity of avoiding strain, overwork and excess in everything.

The atmosphere in the ward was very congenial and I encouraged his joining in with the other patients. With a little extra time we were able to convert the dreaded meal-time into a more enjoyable period.

When Mr. T talked to the other patients on the ward, he began to see that his troubles were comparatively few. After all, he had a secure job in a prominent shoe store and lived in a pleasant rooming-house. Although he had no hospitalization insurance he had some money saved and had no family to support.

He seemed to be getting along very well and I felt that I had had some part in helping his convalescence.

The experience of my two weeks was very interesting as well as educational. The home visits gave me insight into the home ties of the average ward patient. The careful personal study of the patient made me realize that patients have multiple problems. Having seen and heard of some of the home backgrounds we cannot help but realize how much we can teach our patients if we take the time and show the interest.

A group of nuns recently attracted much attention at a western Canada railway station because of the beautiful nylon veils they were wearing. In response to enquiries, one of them explained that they were going to work in southern China and were wearing nylon because of its suitability to the climate of that country.

Hernia in Infants

HERNIA is the protusion of a portion of the contents of a cavity through an abnormal opening in the wall which normally confines it. Originally it was believed that a portion of the peritoneum was ruptured in a hernia; the condition is still termed as "rupture" by many.

Hernia may occur at many points in the abdominal wall. The most common sites of hernia in infants are at the umbilicus and through the inguinal canals and they are identified by these descriptive terms. Hernia may be either congenital or acquired. Cases of the latter occurring in infants, however, are usually dependent upon conditions which are

congenital.

Umbilical hernia occurs very commonly in infants, especially those who are markedly undernourished. It is found more often in female than in male infants. The congenital form, exomphalos, may be observed as soon as the infant is born. It may be very small in diameter. It may be apparent only when the infant cries or strains. It rarely strangulates. As a rule these small hernias do not require any active treatment since they disappear spontaneously as the nutritional state improves or as the infant grows older. Placing a strip of adhesive across the umbilicus in such a way as to prevent the hernia from protruding is the simplest and most effective method of treatment. The doctor will direct the nurse to fold the skin over the umbilicus and strap it in place. Sometimes a large button or coin, wrapped in gauze, is applied directly over the hernia before the adhesive is put on. The adhesive may be a single strip, two inches wide, stretching from hip to hip. Another method is to leave a square over the umbilicus and cut each end in inch-wide tails. Crossing these strips in applying them provides a stronger support. Since the adhesive must remain over the abdomen for several months at least, there may be

some irritation of the skin. Should this develop, it is wisest to permit an interval without the retaining straps, reapplying them when the skin is well. An umbilical hernia that has had no treatment until the infant is ten or twelve months old does not respond to this simple form of treatment. The older the child the more likely he will require sur-

gical treatment.

Inguinal hernias occur in the inguinal canal, the space in the groin through which, in the male infant, the testes descend from the abdominal cavity to the scrotum and the spermatic cord enters the ab-In the female infant, the domen. round ligament of the uterus passes through this opening. Normally this space closes completely. When it is only partially closed, a protusion of the peritoneum occurs forming a small sac. Weakness of the tissues may permit this form of hernia in female infants though three-quarters or more of the inguinal hernias occur in males. Acquired inguinal hernia may follow trauma or strain of any type such as a severe bout of whooping cough. An inguinal hernia rarely causes the infant any discomfort unless it becomes strangulated when the symptoms of intestinal obstruction will arise. Though the latter seldom occurs, immediate surgical intervention is necessary when it does. Even very young infants tolerate a hernia operation well if they are vigorous. Usually, keeping the hernia reduced by the constant application of a suitable truss will be sufficient to control it. A satisfactory truss for a young infant can be made from white wool. A band encircles the abdomen with supporting strands around the buttock, the knot being applied over the hernia. Since the truss will have to be changed frequently, when wet or soiled, the wool can be washed regularly, using warm water, a non-irritating soap, and thorough rinsing.

MAY. 1947 3413

Book Reviews

Nursing Care in Chronic Diseases, by Edith L. Marsh, R.N., S.C.M. 237 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1946. Illustrated. Price \$3.25.

Reviewed by Pearl L. Morrison, Superintendent, Queen Elizabeth Hospital, Toronto.

A nursing textbook dealing with the care of the chronically ill has long been a definite if not recognized need. The chronically ill are now, by their rapidly increasing numbers, demanding more public attention, and the problem can no longer be pushed into a corner and forgotten.

Miss Marsh in her first chapter on "Definitions" will bring some surprises, and it is hoped increased interest. As she goes on to discuss "long-term" illnesses in need of long-term ability from a nurse, she definitely shows that more than practical skill is needed to care for a mind and a body. The nurse must have something definite of herself to give.

Miss Marsh clearly presents for study, not only chronic diseases, but the persons suffering from them, as sick people in need of more and better nursing care. She feels more suitable preparation must be given in the schools of nursing if graduate nurses are to be able to meet this ever-increasing need of the sick and the community.

Certainly every nurse everywhere needs Miss Marsh's book, and I feel sure will find it a most interesting study.

Anatomical Charts for the Training of

Nurses. Edited in collaboration with prominent medical authorities, and accompanied by a booklet on the system portrayed by the chart. Published by Rudolph Schick Publishing Co., 700 Riverside Drive, New York City 31.

Reviewed by Muriel Archibald, Science Instructor, Homoeopathic Hospital, Montreal.

Among other charts portraying certain systems, there is one illustrating the respiratory system, a life-size colored chart, showing in excellent detail organs and accessory organs of this system and their location in the body. The booklet accompanying this gives a simple and uncomplicated description of the respiratory system and would be good material for high school students.

Five charts are used to show the

various organs of the endocrine system. One is a colored, life-size chart showing glands as they are placed in the human The other four are in black and body. white and give examples of the result of hypo- and hyper-function of certain endocrine glands. The examples shown of male and female glandular dysfunction are likely to impress themselves on the student's memory, thereby helping them better to understand and remember those organs associated with the examples. The interdependence of these glands one to another, and especially to the pituitary gland, is well illustrated.

The charts should prove very useful teaching material but, unfortunately, the paper on which they are printed is too thin and too easily torn to have a very long life.

Sir Frederick Banting, by Lloyd Stevenson, M.D. 446 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1946. Illustrated. Price \$6.00.

Reviewed by Katherine MacLaggan, Public Health Nurse, Westmorland County, N.B.

Dr. Stevenson states that Sir Frederick Banting resisted all efforts towards a formula, and in this biography he has succeeded in portraying no standardized character. Those who read this book will have a better understanding of this great Canadian. It is written in a style one feels would have been acceptable to Banting himself. Factual and technical knowledge are presented in an interesting and reasonable manner. The doctor, scientist, artist, teacher and patriot are readily understood through the pen of the writer. It is necessary to read between the lines for insight into the complications of his private life, which is as it should be.

The chapters "The Magic Islands" and "The Prophet in the Valley of Bones" should be presented to every student nurse early in her training so that she may appreciate the value of medical science to humanity. Banting's contributions were many, but in the minds of the majority his gift of insulin to the world was his chief contribution. His "biggest experiment," however, was in terms of guidance to those who worked with him in medical research.

Dr. Stevenson's biography of Sir Frederick

Your Patients Rely on You...



Your Patients rely on you for help and advice. When they ask about antiseptics, you can be certain you are recommending a safe and most effective general antiseptic in 'S. T. 37' Antiseptic Solution.

Nontoxic and nonirritating, this potent germicide is particularly effective in treatment of cuts, abrasions, burns and scalds. Moreover, it is safe to use on open wounds.

Combining a surface analgesic effect with high germicidal action, 'S. T. 37' Antiseptic Solution is ideal as a spray or gargle for treatment or prophylaxis of throat infections.

'S. T. 37' Antiseptic Solution is stable, odorless and stainless. It combats infection when administered full-strength or diluted according to requirements . . . yet is harmless even if swallowed accidentally in full-strength.

'S. T. 37' Antiseptic Solution is supplied in bottles of 5' and 12 fluidounces. Sharp & Dohme (Canada), Ltd., Toronto 5, Ont.



S. I. 37°

antiseptic solution

Banting will have a wide reading public, but nurses will readily appreciate its value to them, and count this book as a necessary part of their hospital and personal libraries.

Toward Mental Health, by George Thorman. 32 pages. Published by Public Affairs Committee, Inc., 22 East 38th St., New York City 16. Distributed in Canada by The Canadian Forum Book Service, 16 Huntley St., Toronto 5. Public Affairs Pamphlet No. 120, Illustrated. in U.S.A., 10 cents; in Canada, 15 cents. Written in simple direct language, to be readily understood by men and women without a medical or nursing background, this little pamphlet would be useful as teaching material for every public health nurse. Everything that she can do to help cut the toll which mental illness takes will pay dividends. While this pamphlet was written to apply in the United States, most of the items in the suggested program are equally applicable in Canada. The material may be read with profit by every nurse - we, too, are subject to feelings of hostility, of guilt, fear of failure, insecurity. There are the things out of which neuroses are made.

A Review of Nursing, by Helen F. Hansen, R.N., M.A. 854 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 5th Ed. 1946. Price \$3.50.

Reviewed by Mrs. Lois MacDonald, Instructress of Nurses, P.E.I. Hospital, Charlottetown.

All who possess this excellent "Review of Nursing" will find it most helpful in reviews of the many nursing subjects. It will be especially useful to the instructors as it is time-saving since the reviews are systematically arranged. Often we are prone to ask questions in one set way; by using these reviews the student may view the subject from different angles and gain a broader knowledge.

The correlation of chemistry with nursing is especially good as too often students and teachers think of this as a separate study rather than connecting it with the various nursing procedures.

The students will find this book very valuable as they may test themselves in the different subjects. If they are unable to answer

many questions without referring to answers, it will prove to them that much more study and learning is required in that subject.

The busy head nurses and supervisors will find this book a very quick and effective means of review.

Orthopedic Nursing, by Robert V. Funsten, M.D. and Carmelita Calderwood, R.N. 602 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co., Ltd., 388 Yonge St. Toronto 1. 1943, reprinted 1946. Illustrated. Price \$4.25.

Reviewed by Margaret Orr, Superintendent, Shriners' Hospital for Crippled Children, Montreal.

This is a book written jointly by an orthopedic surgeon and a nurse consultant in orthopedic nursing, dealing mainly with the underlying principles of the fundamental surgical and nursing techniques in the care of orthopedic patients.

At the outset the authors state that it is not intended to be encyclopedic, therefore, it is not designed to "take the place of a comprehensive reference text on the subject of orthopedic surgery."

The book is divided into twelve sections with each section followed by a list of references and, with the exception of the first section, a group of questions for study.

The first section takes the form of an introduction for the teacher and the student, and is entitled "Toward a Complete Understanding." This is a valuable chapter to the student nurse as it not only emphasizes the place of the nurse in the scope of nursing care for the orthopedic patient, but also the place of orthopedic nursing skills in the general nursing course, and how closely they may be related to all branches of nursing in order that the patient may be treated as a whole rather than in a series of disconnected procedures.

Sir Robert Jones is quoted as having said, "It can never be realized too widely that deformity is an unnatural and preventable affliction, which treatment may alleviate or cure, but which a more complete understanding could abolish."

The remainder of the twelve sections cover all aspects of orthopedic nursing care, in relation to both children and adults. The book is printed in clear type, copiously illustrated, and should prove a ready source of information for all nurses.

VOLUME 43 NUMBER 6 MONTREAL JUNE 1947

THE CANADIAN NURSE



The Paraplegic Patientby Dr. G. Gingras

Meal Planning and Preparation by H. R. Crawford



Apple Arch



Pr : by (. McCorqualale



had on duty, the Government would probably have a brand new class of capitalists to tax. Every nurse, however, realizes that it pays big dividends to obtain rapid symptomatic relief by the use of a tested and effective analgesic.

Tabloid' Brand 'Empirin' Compound is just such a preparation. Its formula has won virtually universal approval for its effective analgesic action, while the purity of its ingredients and careful compounding ensure a rapid, dependable effect. For a trial sample, simply tear out and mail the sample offer below.

Each product contains

'EMPIRIN' (Brand of Acetylsalicylic Acid) gr. 3½
PHENACETIN
CAFFEINE
gr. ½
gr. ½

TABLOID BANG EMPIRIN BANG COMPOUND Please send me without obligation a sample issue of 'Tabloid' Brand 'Empirin' Compound.

Name

Address





way to help my 'occupational' skin problems -frightfully chapped hands and oh, so tired feet.

"Soon I began to hear about NOXZEMA Skin Cream, the medicated formula scores of nurses have used for years.

"I tried NOXZEMA first as a hand cream. Greaseless and stainless, it helped soothe and soften my rough, red hands -- almost overnight! Then I learned that a cooling NOXZEMA massage took the burn out of my weary feet.

"Now I use NOXZEMA regularly for my complexion -- as a night cream and make-up base...and how quickly it helps unattractive skin blemishes!

My skin is almost as smooth and soft as a baby's.

"Yes, Aladdin can keep his lamp -- I'll take my little blue jar!"

JUN1, 1947

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawae

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR JUNE, 1947

I Am a Canadian		425
The Paraplegic Patient	G. Gingras, M.D.	427
Rehabilitation of the Paraplegic Veteran	P. Green, M.D.	431
Living on Wheels	D. G. Petrie	432
Meal Planning and Preparation	H. R. Crawford	434
Role of Pathology in Cancer Control	J. E. Kurtz, M.D.	437
An Orientation Program	N. D. Lambert	441
They Too Are Our Patients	P. Stiver	443
Nursing with UNRRA in Greece	M. E. Henderson	446
L'Infirmière et la Culture Générale	G. Hébert, M.D.	447
Interesting People		452
Notes from National Office		459
To Meet Mounting Costs		463
Notes du Secrétariat de l'A.I C.		464
So It's Your Graduation Day	B. Laycraft	470
Book Reviews		474
News Notes		479
Official Directory		487

Subscription Rate: \$2.00 per year — \$5.00 for 3 years; Foreign & U.S.A., \$2.50; Student Nurses, eighteen months for \$2.00. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address: Four weeks' advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Educrial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to 522 Medical Arts Bldg., Montreal 25, P.O.

Keep Fit!

FOR YOUR JOB ... AND FOR YOUR LEISURE HOURS

with

"NEO-CHEMICAL" FOOD TONIC

In these busy days of help shortages on hospital staffs, you owe it to yourself to keep fit so you can enjoy both your work and your off-duty hours. NEO-CHEMICAL Food Tonic is the most complete vitamin and mineral food supplement now on the Canadian market. Supplement your diet with this inexpensive source of the vitamins and minerals so necessary to perfect health. Feel your best both on the job-and off!

SPECIAL OFFER TO CANADIAN NURSES

We shall be glad to send you a supply of "Neo-Chemical" Food for your own personal ase. Please mention this magazine when writing.

Charles E. Frosst & Co.

Montreal

Canada



Since 1899 the Symbol of Progress in Pharmaceutical Research



Reader's Guide

Twice a year the nine provincial nurses' associations are asked to take stock of their various accomplishments and report them to the Executive Committee of the C.N.A. These segments of history of nursing in the making are summarized under the Notes from National Office. They present a picture of continuing growth and activity, well worth your consideration.

Almost every periodical has had articles or pictures showing what is being accomplished in the rehabilitation of those veterans whose war injuries resulted in paralysis. We are very pleased to be able to present an interesting series on this topic. The first article is by Dr. Gustave Gingras, who is in charge of the Paraplegic Centre at Ste. Anne's D.V.A. Hospital in the Province of Quebec. Dr. Paul Green spoke on this topic to the nurses in Manitoba where he was in charge of the paraplegic ward of Deer Lodge Hospital. Rounding out this series, D. George Petrie gives the personal slant to the material which the doctors have presented. As soon as he was able, Mr. Petrie returned to the studies at McGill University which had been interrupted by the war. Perhaps the most valuable lesson which any of us can draw from this series is the thought that we should refuse to think of these people as invalids; that we can render them the greatest service if we treat them like human beings instead of like fragile pieces of Dresden china; that we help them in their gallant return to civilian life by observing the golden rule - "do as you would be done by."

From time to time we read of new discoveries in relation to cancer. A never-ending search for the cause is being prosecuted by the world's keenest scientists. Well in the van

of this group are the pathologists in our hospitals who scrutinize each specimen with meticulous care. We are indebted to the Canadian Cancer Society, Toronto, for the excellent description of the role of pathology in cancer control written by Dr. John E. Kurtz.

In the final article in the excellent series on nutrition which has been reaching you for the past few months, Mrs. H. Ruth Crawford gives us some very practical suggestions on the planning and preparation of meals. This information will help the public health nurse to advise the families wisely during her visits to the homes. It will be useful also to the nurse in hospital who is counselling her patients regarding the importance of good, nutritious meals.

Pearl Stiver makes an appeal for greater understanding of sufferers from the venereal diseases. Miss Stiver is supervisor of nurses in the Division of Venereal Disease Control of the Ontario Department of Health.

Noreen D. Lambert of Prince Albert, Sask., has given us a broad picture of the techniques employed in the introduction of new staff in a large hospital. Perhaps some of the current unrest could be eliminated if nurses were quickly made to feel at home in a strange hospital.

How are you doing? The May issue of the *Journal* was sent out to subscribers in each province in the following quantities: Alberta, 847; British Columbia, 1,187; Manitoba, 411; New Brunswick, 577; Nova Scotia, 542; Ontario, 3,388; Prince Edward Island, 110; Quebec, 1,066; Saskatchewan, 595.

Preview

The nursing care of urologic patients presents many problems. Considerable emphasis has been placed on the necessary preoperative care but in the opinion of **Dr.** Charles A. Cawker, of Vancouver, the post-operative care of these patients has not been as well emphasized to date. He has prepared a detailed account of the

specific care for various types of urologic conditions. This article will be featured next month. As a companion article, the special features of nursing care requested for post-operative cases of prostatism will be discussed by Evelyn Myers of Saint John. Thus west and east unite to present an important topic.

AN EFFECTIVE TREATMENT FOR DERMATOPHYTOSIS

Sopronol is effective, yet mild. It is not only an efficient fungistat, but is practically nonirritating and nonsensitizing. The active agent is propionic acid — an ingredient of human sweat — nature's own defence against fungous infection.



And daily dusting with Sopronol Powder will destroy fungi lurking in socks and shoes.

3 FORMS . . . 3 USES

SOLUTION

2 oz. bottles

Convenient for office treatment

OINTMENT

1 oz. tubes
For application
at bedtime

POWDER

2 oz. tins

For daytime use, and for prophylaxis

Solution and ointment contain sodium propionate 16.4%, and propionic acid 3.6%. Powder contains calcium propionate 15% and zinc propionate 5%.

SOPRONOL



JOHN WYETH & BROTHER (CANADA) LIMITED • WALKERVILLE, ONTARIO

JUNE, 1947 413

NOW IN

THREE CENTURIES OF

Dr. JOHN MURRAY GIBBON AND

Over forty pages of illustrations. A record of fact that reads like fiction.

SOME

MACMILLAN

Aids to

ANATOMY AND PHYSIOLOGY

MEDICAL NURSING

SURGICAL NURSING •

TRAY AND TROLLEY SETTING

TUBERCULOSIS

HYGIENE

and other Titles

Bailey: 101 CLINICAL DEMON-

STRATIONS FOR NURSES

Bailey: OPERATIVE SURGERY

FOR NURSES

Naylor: FRACTURES

Fitzsimmons: TEXTBOOK FOR ATTENDANTS IN MENTAL

HOSPITALS

Kraines: MANAGING YOUR

MIND

Bailev: NURSING MENTAL DIS-

ORDERS

Noyes: TEXTBOOK OF PSY-

CHIATRY

Strecker: DISCOVERING OUR-

SELVES

THE MACMILLAN COMPANY

70 BOND STREET

THE PRESS

CANADIAN NURSING

MISS MARY MATHEWSON, R.N.

The story of an inspiration that became a profession.

RECENT

NURSING TEXTS

Proudfit: NUTRITION AND DIET

THERAPY

Emory: PUBLIC HEALTH NURS-

ING IN CANADA

Craig: CHILD AND ADOLES-

CENT LIFE

Smillie: PREVENTIVE MEDICINE

AND PUBLIC HEALTH

Lerrigo: CHILDREN CAN HELP

THEMSELVES

Norlin: EVERYDAY NURSING

Van Blarcom: GETTING READY

TO BE A MOTHER

Harmer: PRINCIPLES AND PRACTICE OF NURSING

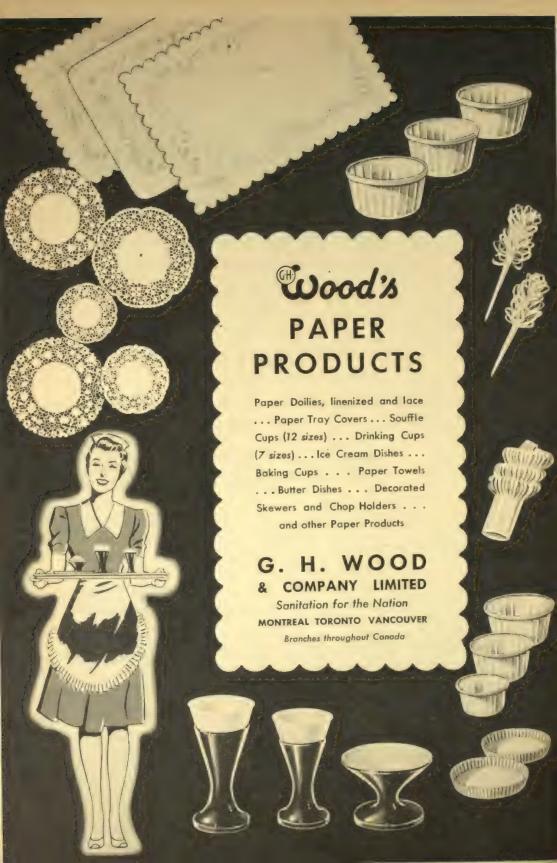
Kimber: ANATOMY AND PHY-

SIOLOGY FOR NURSES

Morse: THE MEDICAL SECRETARY

OF CANADA LIMITED
TORONTO 2

JUNE, 1947 415





The triple heat treatment given Carnation results in the formation of a fine, soft, granular curd, instead of the firm, tough curd of untreated milk. Allergenic properties are decreased. Irradiation to 400 units of vitamin D per pint of evaporated milk satisfies the requirements of the normal full-term infant and affords needed protection for the expectant mother.

Carnation Milk is now generally available in all parts of the country, to meet the needs of the medical profession.

Carnation



William or milliam manner

"FROM CONTENTED COWS"



Milk

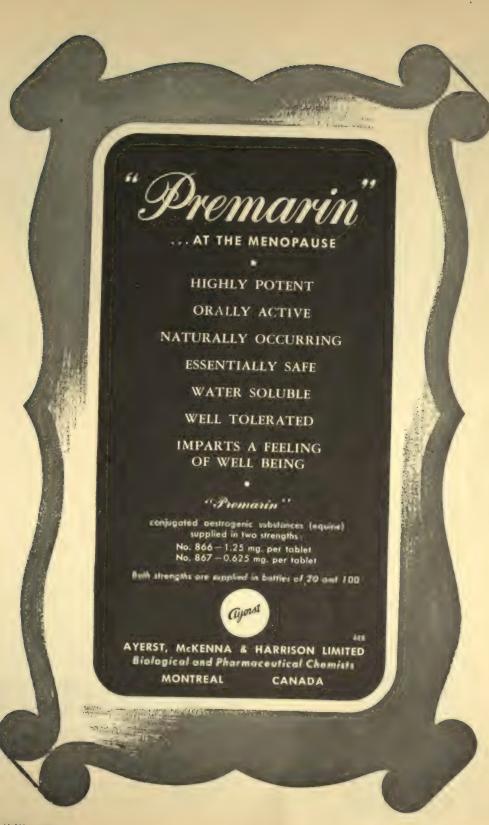
A Canadian Product

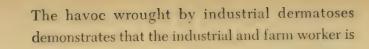


Into every tin of Nestlé's Evaporated Milk goes the skill gained in eighty years' experience in making infant diet foods all over the World.

Nestlé's Milk Products
(Canada) Limited
METROPOLITAN BUILDING, TORONTO







"just as sensitive as an artist"

to chemical, mechanical, biologic, and plant irritants

Control of itching is singularly simple with Calmitol Ointment. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate, reduce the sensitivity of cutaneous receptors and nerve endings by raising their sensory threshold. Free from stimulating or keratolytic drugs and free from potentially harmful phenol or cocaine derivatives, Calmitol does not cause unwanted by-effects.

- checks itching, smarting and burning which interferes with concentration and acuity.
- 2. Minimizes danger of infection.
- **3.** Helps protect against further exposure and continued dermal injury.

CALMITOL

The Leeming Miles Co. Lid.
NOTE DAME ST. W., MONTREAL I, CANADA



ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE. NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to:

Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. O.

07

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

QUEEN'S UNIVERSITY SCHOOL OF NURSING

COURSES OFFERED

- Degree Course leading to B.N.Sc. Opportunity is provided for specialization in final year.
- 2. Diploma Courses:
 - (a) Teaching, Supervision in Schools of Nursing.
 - (b) Public Health Nursing.

For information apply to:

DIRECTOR
SCHOOL OF NURSING
QUEEN'S UNIVERSITY
KINGSTON, ONTARIO

McGill University School for Graduate Nurses

COURSES OFFERED

-Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

040

-One-Year Certificate Courses-

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to:
School for Graduate Nurses
1266 Pine Ave. W.
McGILL UNIVERSITY, MONTREAL 25

TORONTO HOSPITAL

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.



... the renewable fabric finish that resists dirt ... soil and ... moisture!

Uniforms stay crisper, cleaner-looking longer . . . wash more easily . . . when they are protected with Johnson's DRAX! And both these advantages mean a cutting down of laundering costs!

DRAX... made by the makers of Johnson's Wax... is an amazing new, *invisible* fabric finish that gives each thread of the fabric the wonderful protection of wax. Dirt slides off, water and liquids wipe easily away... because dirt is not ground into the fabric it washes easier, cleaner without fabric-fatiguing rubbing and scrubbing.

DRAX is grand for curtains, tablecloths, place mats and other washable things, too. It saves so much time in the washing . . . so much wear . . . and keeps things looking cleaner longer, it's well worth looking into. Find out about DRAX today!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

II NL 191;



The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER SIX

MONTREAL, JUNE, 1947

encertification contential territorial contential conte

I Am a Canadian

N July 1, 1947, Canada celebrates the eightieth anniversary of the notable event, Confederation, which linked all of the broad stretches of our land into one Dominion. During these eight decades there have been marked changes in the character of our industrial life and in the expansion of our worldwide commerce. There have been great advances in the cultural life of our people. Education on levels all the way from kindergarten to post-graduate university work is available free or at nominal costs. Music, art, drama flourish in our midst. Scientific research, medical practice, the care of the sick and the well have raised our standards of service to enviable heights. Now, with the coming into effect of the Canadian Citizenship Act on January 1 of this year, we proudly look forward to the eightieth celebration of Dominion Day and pledge our love and loyalty as Canadians. French-Canadians or English-Canadians, Finnish, Icelandic or Polish; whatever our racial origin may

have been is of less import than the fact that we are all Canadians, pure

and simple.

The fact that the law has been passed, that for all purposes, at all times and in all places we may call ourselves Canadians, does not of itself make us any better or truer citizens. There are points of deeper significance which we might pause and consider at this time. Dr. Norman MacKenzie, president of the University of British Columbia, has expressed some of these feelings most adequately:

"It is true that simply by calling ourselves Canadians we will not automatically become better citizens of Canada, but the realization of what full citizenship means should impress upon us that becoming Canadians is more than an honor and privilege. The new Oath of Allegiance itself implies a sense of responsibility and service to our country. The Oath concludes with the statement that 'I will faithfully observe the laws of Canada and fulfil my

JUNE, 1947

duties as a Canadian citizen so help me God.' The more we put into our sense of citizenship, the more we are likely to get from it., Another point is the matter of Canadian unity. Canada is a large and sparsely populated country and within our boundaries are represented a great number of different racial origins. For these reasons there is lacking in our country a sense of unity and cohesion. There are still many differences between groups of people which must be broken down. The barriers between French- and English-speaking Canadians is only one of these. The Canadian Citizenship Act is another step towards the solution of this problem, and in this respect it is significant. It should help to give us all a sense of pride in Canada and common identity, and common patriotism.

"Finally, there is a point which is sometimes overlooked. In passing the Canadian Citizenship Act no attempt is being made to whitewash us all with the same brush, as it were. The Government has no desire to destroy completely the ties which unite new residents of Canada with the country of their origin, nor to minimize the contribution which naturalized Canadians can make to our country by bringing with them the richness of their varied cultures. I will always be proud of the fact my ancestors were Scottish, just as a Canadian from Ireland, France, or Norway will always be proud of the customs, culture, and tradition of their own or their parents' home-land. We will, and should, however, be even prouder that we are Canadians. The very fact that Canada represents a cross-section of all peoples of the world should bring a deeper significance to the granting of citi-

zenship.

"Of course, it is quite true that if our citizenship, our sense of nationalism, were ignorant or selfish it could be dangerous. It should be an intelligent form of citizenship. We can be proud of the achievements of Canada as a nation but we must at the same time be fully aware of the contribution which Canada can and must make to the world generally. Our contribution to world government should increase with our growing strength and importance. In this way, a sense of Canadian citizenship can have a very positive value. The fact that one is a member of a family does not make one a poorer citizen in the community. The more one realizes one's responsibilities as a member of a family group the better community citizen one becomes. And on national and international scale, the better Canadian or Englishman one is, the better world citizen one becomes. Every citizen must have a base from which to start. Citizenship begins in the home and goes from there to the community, the country, and then to the world as a whole. Nationalism, considered in this way, is not a barrier to international brotherhood — it is an essential prerequisite for it. And no matter what type of world citizenship may eventually be evolved, our experience and training as good Canadians will stand us in good stead.'

Coming Events

· Manitoba Association of Registered Murses

Event: Instructors' Workshop.

Date: June 17-20, inclusive, 9:30 to 12:00 a.m., 2:00 to 4:30 p.m.

Place: Nurses' classroom, Misericordia Hospital, Winnipeg.

Group: All instructors in schools of nursing in Manitoba.

Special Comment: The purpose of this annual workshop is to revise and set up course outlines for the courses tested in the Qualifying and Registration Examinations. This June the committee proposes to set up course outlines for courses tested on the Registration Examinations.

The Paraplegic Patient

G. GINGRAS, M.D.

PARAPLEGIA is paralysis of the lower extremities, or of the lower part of the body. The term quadriplegia is applied in cases of high spinal cord lesion in which the use of all four extremities is impaired. Depending upon the extent of nervous tissue destruction the paraplegia is not always complete and may be divided into three types:

- 1. Complete motor paralysis.
- 2. Some motor power, but inability to walk.
- 3. Ability to walk with varying amounts of difficulty.

The etiology of paraplegia is either trauma or disease. Common traumatic causes include: gun-shot wound of the spine, fracture of a vertebral body with compression, fracture-dislocation of the vertebral bodies, concussion, and occasionally an acute herniation of an intervertebral disc. On the other hand, tumors, abscesses within the spinal canal, and other diseases of nervous tissue, such as poliomyelitis and disseminated sclerosis, may cause paraplegia.

Up to now, efforts have been concentrated on the traumatic paraplegics, or quadriplegics, since they offer the best chance for successful rehabilitation, their condition being stable rather than slowly progressive as in the case with most of the non-

traumatic spinal diseases.

Following transection of the spinal cord there is an immediate motor paralysis and loss of sensation below the level of the lesion. The bladder and bowels become paralytic. There will be an acute urinary retention unless suprapubic cystotomy or urethral catheterization is performed.

Until recently it has been impossible to prevent chronic urinary infection accompanied by elevated temperature, general malaise, gastric disturbances, and loss of appetite. This occurs especially during the first few months following the injury, but may manifest itself with acute onset any time

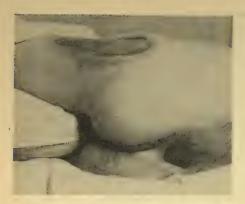
after the initial paralysis. Before the discovery of sulfa drugs, and, more recently, penicillin, most paraplegics succumbed to the overwhelming effects of urinary infections in spite of surgical and nursing care. At the present time. however, these cases are transferred to appropriate centres where they are treated by chemotherapy in conjunction with mechanical methods of warding off infection. If a catheter has been inserted, the bladder is irrigated at four-hour intervals to prevent the accumulation of heavy sediment and the subsequent formation of stones. An acid solution is used, preferably "M" or "G" solution.

The necessity for a permanent, specifically trained, competent group to staff a Paraplegic Centre cannot be over-stressed. Paraplegics must be hospitalized for lengthy periods, and a sympathetic, understanding staff is a prerequisite in gaining the confidence and co-operation so important in maintaining the patients' morale. Beside the physician-incharge and a group of specialists who may be called upon in consultation,



Complete cauda equina lesion walking with full-length braces and crutches.

JUNE 1947



Patient with 3 large pressure sores, 2 on greater trochanters and one on sacral region before lying on abdomen only.

the staff consists of a head nurse and her assistants — nurses and orderlies - of whom at least two are trained in the treatment of pressure sores, dressing technique, and the management of the different types of apparatus used in the Centre, such as tidal and continuous irrigators, care of irrigation sets, and use of cystometer. They should be familiar with such neurosurgical work as lumbar punctures and manometric tests. Also there are physiotherapists, occupational therapists, an educational officer, a casualty rehabilitation officer, medical-social workers, and physical training instructors.

Representatives of these various departments form a Rehabilitation Board which meets at regular inter-



Same patient after remaining on his abdomen for 4 months. He is now ready for plastic procedures. Note the space between the pillows to protect the iliac crests.

vals to discuss treatment, rehabilitation, individual cases, and general problems arising in the Centre.

The nurses of the Armed Forces who looked after the cases of spinal injury merit a great deal of credit because nursing care, in the early stage, is one of the most important factors in the survival of these cases. A nurse, or anyone who accepts work with such cases, should know in advance that she is not only expected to carry on with the ordinary treatment of the sick, but must also make conscious effort to cheer the patient and help keep up her or his morale by her attitude and good If good physical rehabilitation is expected, the patient's state of mind cannot be neglected without disappointing results. There must exist harmony and confidence between the nurse and patient, and when attending various social functions it is expected that one of the nursing staff will accompany him, just as she must share in the social activities of the ward.

Paraplegics are extremely susceptible to pressure sores but, with proper nursing care and training of the patient, they can almost always be prevented. Many pressure sores were found in veteran paraplegics and in certain cases of civilian paraplegics admitted to this Centre. Up to now, no local treatment has proved satisfactory and recently many of these sores were closed by turning large It has been estabplastic flaps. lished that if the patient is turned every two hours and the pressure points, of which the most important are the sacral region, the iliac crests, greater trochanters, and heels, are protected, no pressure sores will occur. If the patient is lying on his back or on his side, precaution should be taken that there is no friction between the knees or the malleoli.

To prevent decubitus ulcers, or to hasten their healing, most of the paraplegics remain on the abdomen for long periods, are rubbed with alcohol every two hours, and their pillows "plumped." Since some of the patients have suprapubic catheters, pillows are placed under the abdomen and thighs, leaving a space for the tubing and also keeping the iliac crests free from pressure. Of course, the patient must be carefully watched at all times to see that the bed and skin are perfectly dry and that the linen is free of foreign objects, wrinkles, etc.

The movement of turning the patient from side to side not only prevents the formation of decubitus ulcers but also helps greatly in draining the urinary tract. must remember that bedridden patients, especially paraplegics, are likely to develop kidney and bladder stones. Recently, the Sanders Vasoscillating bed has been recommended and used in some of the paraplegic Not only is kidney and centres. bladder content moved by the rotation from side to side but also it is directed down the ureters by the tilting of the bed on a transverse axis, like a see-saw.

Depending upon the type of bladder. paraplegic cases are submitted to different methods of bladder irrigation. The automatic bladder, which empties by reflex at regular intervals, has the tidal irrigation. The bladder is filled with an antiseptic solution and when the desired intra-vesical pressure is reached, the fluid is siphoned off, thus submitting the bladder to passive expansion and contraction alternately. Others with large atonic bladders will be treated with the continuous irrigation. The catheter used in these cases is a Foley two-way catheter. The antiseptic solution enters through one branch, washes the bladder, and runs out through the other branch. As soon as the bladder infection has cleared, the catheter is removed. Patients with automatic bladders are trained to void at regular intervals and wear a rubber urinal to which is attached a reservoir for the collection of the urine. If the bladder is of the large atonic type, they are taught to urinate by applying manual pressure to the abdomen. These arrangements permit the patient to attend various functions,

or go for drives, and still manage to be in a position to attend to his needs at the stated time and not have to worry and fret lest there be an "accident."

REHABILITATION

Rehabilitation of paraplegics should begin immediately, or as soon as possible after the injury. This is why medical authorities are so keen on having them transferred to specialized centres at the earliest possible date. Physiotherapy, consisting of massage to the paralyzed, or partially paralyzed muscles, and passive movements of the joints of the lower extremities, must begin at once. Special precautions are taken to prevent flexion deformity of the toes and feet by the use of night splints and Simultaneously, the foot boards. patients are instructed in special exercises designed to develop the muscles of the upper extremity to prepare them for the extra work they must now do.

As soon as the general condition of the patient is satisfactory enough to permit it, and there are no com-



A wheel-chair patient is able to participate in sports and recreation. Note the detachable arms of wheel-chair, which permits free movement of arm.

plications, he is allowed to do matwork, consisting of special breathing exercises, weight-lifting, crawling, getting from wheel-chair to mat and from mat to wheel-chair, etc. When the patient is permitted to leave the bed he is taught how to get from bed to wheel-chair and vice versa, how to get on and off the toilet, in and out of the bathtub, shave himself and attend to all the daily necessities When the of life, independently. patient has the ability to perform all of these tasks, and it is felt that his upper extremities are strong enough, he will be permitted to stand up in the walker and later between the parallel bars with knee and ankle articulations immobilized. the meantime, measurements crutches and braces are taken. braces are steel bars on either side of the legs which correct the footdrop and are made to bend at the knees when necessary, as when the patient wants to sit down. Depending upon the height of the lesion, there will be a leather belt uniting the upper ends of these braces, at the waist, and, if necessary, as it is in a few cases, a thoracic corset. Now the patient is fitted with braces and, providing that they fit correctly, he is allowed to do standing and balancing exercises. When the fear of falling is overcome, he is taught one of the numerous methods of walking with crutches and The three most popular methods are the "swing to," "swing through," and the "four-point." They are taught how to deal with obstacles which are taken for granted by the ordinary man, such as curb-stones, stairs, slopes, getting in and out of a These feats are always car, etc.

hazards for them to conquer.

This is only one part of the rehabilitation of paraplegics. While doing all of these exercises and building up the salvaged muscles, members of the staff are investigating the possibilities of a job for these people, governed by their individual capability and previous education. Diversional and academic courses are given concurrently so that the patient is completely rehabilitated.

Rehabilitation cannot be forced upon anyone. With paraplegics, particularly, it takes a considerable amount of will power and fortitude to reach a point where one can leave the hospital and return to everyday life. Doctors and nurses in attendance can help to achieve good results but the largest part in the rehabilitation program is to be played by the individual patient.

BIBLIOGRAPHY

1. Botterell, E. H., O.B.E., M.D., M.S., F.R.C.S. (C) and A. T. Jousse, M.D., Carl Aberhart, M.D., M.S., J. W. Cluff, M.D. Paraplegia Following War. *Canadian Medical Association Journal*, 55, 1946. pp. 249-259.

2. Deaver, George G., M.D., Medical Director, Institute for the Crippled and Disabled, New York City, and Mary Eleanor Brown, M.A., Physical Therapy Technician, Institute for the Crippled and Disabled, New York City. The Challenge of Crutches. Archives of Physical Medicine, Sept. 1945.

3. Deaver, George G., M.D., and Mary Eleanor Brown, M.A., Institute for the Crippled and Disabled, New York City. Physical Demands of Daily Life.

4. Veterans Administration, Medical Rehabilitation Division, Department of Medicine and Surgery. What's My Score? V.A. Pamphlet, 10-10.

White Shadows in Coal

Coal is not usually associated with beauty. Yet, the x-ray discloses striking patterns in that essential product. Millions of years ago in the morning of time, strange vegetation flourished in a world of stranger creatures. It was then that the woody parts of plants, the leaves, bark, spores and resin, sank into the earth, and, after the pressure of ages beyond count, solidified and made the white shadows in black coal which, beneath the.

inquisitive eye of the rays, tell of the contribution they made to the black diamonds of industry. Geologists can read the story the radiographs relate, and tell interesting things about the coal's quality. And even the layman is surprised and impressed when he sees the delicate, lacy designs, the gem-like blebs of pyrite, that bedizen common coal beneath the rays.

Rehabilitation of the Paraplegic Veteran

PAUL GREEN, M.D.

Not so long ago an article with this title would have had a hollow ring, as few paraplegics lived long enough to be rehabilitated. Indeed as late as 1940, Elseberg, in his textbook, said: "The patient with a complete transverse lesion of the cord, if he lives for any length of time, is fully incapacitated for work for the remainder of his life." We now know that such a gloomy outlook is unnecessarily pessimistic. Paraplegics can live a normal span and can lead a useful, happy, and active life.

When he is first injured, a paraplegic lies, as it were, on a quagmire, and any weakening of his supports will permit him to slip deeply in, so that extrication may be very difficult, if not impossible. How he is protected from such weakening effects as infection can produce, and is gradually brought back to firm ground again, is not to be considered here. It requires the combined efforts of the urologist, neurosurgeon and physician to accomplish this, but none can deny that patient and skilful nursing deserves the greatest share of credit for what has been done.

Our experience has been gathered from a group of thirty-eight paraplegics who sustained their injury during the late conflict. consider one of these men, after he is restored to the state where he has no bed sores, no urinary tract infection, no flexor spasms, and has developed automatic bowel and bladder functions. He is lying in bed and has no "feeling" below his waist, nor can he move either lower limb. He can be up in a wheel-chair. That is an easy first step, and a very important one, as it enables this man to make social contact with the outside world.

It must not be thought that during those long months when he was lying in bed nothing constructive

was being done. A subtle reconditioning has been taking place — he has been developing the muscles of his upper extremities by means of a bar over his head, fastened onto his bed. He has been having massage and muscle re-education from the physio-He has been therapy department. receiving lectures on how he must Above all, he look after himself. has been under considerate and affectionate nursing care, which has built up his morale to the point where he is willing to look ahead and plan for the future. There is no point in trying to get a patient up, if he has nothing to get up for.

Once he is up, rapid progress towards the future is possible. The first objective is to learn to walk. For this he must develop powerful arm muscles by exercising on mats and bars, and once again the physiotherapists play a great part. Splints are fitted, designed to keep the powerless limbs from buckling, and with locks in them so that bending at the knee can occur on sitting down. With these splints and crutches, progression is possible by swinging the body weight with shoulder and hip, and allowing the limbs to rock forward like a pendulum. different gaits can be learned, and considerable proficiency is attained.

Our man is now able to get about; he has been taught how to care for his skin, bladder and bowels. The next step is to decide what work he will do. There are many trades which lend themselves admirably to adaptation for a paraplegic. Watch repairing, plastics, telephone repairs, typewriter repairing, and many similar sedentary occupations can be followed. There must be many that have not occurred to us. Some organizations have been most helpful in teaching these trades. Other groups have sponsored handicrafts, such as leather work and work in plastics. Other paraplegics are running res-

JUNE, 1947

taurants and other businesses with the help of relatives or friends. One man is a very busy insurance salesman. Still others are going back to school.

Once established in some field they can, and do, find themselves places in which to live, and are weaned completely from hospitals and medical staffs. Many had families of their own before they were injured; others have taken the matrimonial

plunge after rehabilitation.

It can thus be seen that their future depends on their own intelligence, initiative, ambition, and on the strength of their arms and nimbleness of their fingers. They have a basic independence in their pensions. They know that the hospital and staff are always ready and glad to help them. We expect them to return periodically for check-over.

It has been a privilege to have been

able to observe this energetic and ambitious group of young men at work and at play. They have organized a nationwide Paraplegic Association, which has attracted the attention of the paraplegics in the United States. They have a newspaper of their own, The Caliper, and all in all they are an up-and-coming group.

It is a delight to contrast them with the paraplegic of a few years ago, lying hopelessly in bed, a mass of ugly bed sores and struck with a succession of urinary tract infections, which eventually killed him; while out in the corridor some relative or friend stood, building up the courage to enter the room and stand the pitiful sight

and the ghastly smell.

When one sees such a contrast, one cannot help but wonder whether a little thought and planning in some other chronic conditions might not provide results as gratifying as these.

Living on Wheels

D. GEORGE PETRIE

In other articles under this cover, the doctors have discussed the medical treatment necessary to bring a paraplegic back to a measure of physical competence and enable him

to assume a useful role.

There is another side to the problem. How does the paraplegic become reconciled to his disability inorder to make use of his physical retraining? The answer to the problem belongs properly in the field of psychiatry. Though I know nothing of that science, I am a complete lesion paraplegic and will attempt to throw some light on the matter from the point of view of personal experience.

Whether the paraplegic received his injury on the battlefield, in a car accident, or through infection, his problem of mental readjustment remains essentially the same. The veteran casualty has the initial advantage of financial security since his treatment and pension are "on the government." The civilian has the added burden of treatment expenses (in part) and provision for his dependents while in hospital.

As soon as the patient regains consciousness and discovers that he can no longer move his legs, his immediate reaction (and the doctor's hope) is that it is only a temporary affair. For the very fortunate ones, it is. But it is with the others that we are concerned. Recovery, if any, usually takes place during the first three months. After this time has elapsed, without improvement, the man must settle down to face the facts.

At first, the realization that permanent disability is inevitable, is an overpowering experience. There follows a period of deep frustration and disillusionment when the future looks black and forbidding. The man's greatest enemy at this stage,

and thereafter, is self-pity. It is a luxury only permitted healthy people—once he surrenders to it, he is lost. It is very easy to set up a series of defence mechanisms and justifications for not moving out of his bed nor attempting anything which he feels he cannot do. His friends and medical assistants can help him a great deal by encouraging his independence—allowing him to do everything within his power from a wheel-chair—thus making him feel useful. Sympathy of the wet-handkerchief variety is poison.

The man's mind must be directed away from himself and towards a hobby or some other absorbing pursuit. This is supplied partly by the occupational therapy departments. O.T., however, does not provide him with a future. Before he becomes convinced that he is out of the running, the paraplegic must be shown that there are still many fields of endeavor in which he can compete on even terms with the able worker. The practice of finding soft jobs should be discouraged; the man should feel that he is earning his own way on even terms with the rest. Where return to his old job is impossible, the man's ability should be assessed and he should be encouraged to select a vocation which does not place him at a disadvantage. In such fields as watch-making, jewelling, insurance selling, and office work of most types, many paraplegics have made satisfactory adjustments.

In any case, the man must be made to realize that it is not what he has lost, but what he still has left which is important. The paraplegic must capitalize on the use of his hands and brain.

To the new paraplegic, the prospect of returning home from the hospital is not as pleasing as you think. The hospital offers an unusual amount of security. In the event of sudden flare-ups, medical help is on the spot. His home is usually many miles from the hospital and the return ride, with a high temperature, is far from comfortable.

Also, at home he is met by a procession of old friends who greet

him with a misty eye and almost invariably err in the direction of oversolicitousness. This is a ticklish problem. Friends and relatives must learn just how much help the man needs and where. This involves a major personality readjustment in the man. If he is used to doing everything for himself, he must be prepared to accept a compromise.

It is important that frequent visits be arranged between the patient and his wife or parents and that several trial week-ends be spent at home. This serves as a form of indoctrination for the relatives and makes the

first trip home much easier.

The greatest physical problem affecting the social readjustment of the paraplegic is the paralysis of his bladder and bowels. In addition to the physical discomfort and inconvenience, it affects his sense of security. It takes a long time to build up confidence in rubber urinals and, even then, the confidence is shaken regularly by such happenings as are related below. It is acutely embarrassing to find yourself guilty of a misdemeanor which your three-year-old nephew has just overcome.

One chap relates an incident which occurred during his first visit home. Inadvertently, he neglected to close the stop-cock on his rubber urinal (a cardinal sin among paraplegics!). The net result was a puddle on the living-room floor. The family tried to cover up the incident by diplomatically blaming it on the dog. This further complicated the situation by evasion, and was probably enough to make the lad wish he had never left the hospital. In such a situation, (and it happens frequently), a sense of humor is the only way out.

A similar incident happened to me this past year. During a party at a fraternity at McGill, my urinal, (they are beastly things!) became blocked, producing a precarious situation. A few of the lads hustled me upstairs where we attacked the problem in high humor, merely because I had previously mentioned that such things did happen.

These unhappy events are men-

tioned because they are the things which are continually cropping up

in a paraplegic's life.

As far as marriage is concerned, paraplegia imposes the problem of sexual incompetency. For couples previously married, readjustment to this problem is difficult but not impossible. Success depends largely on the individuals concerned. There have been many successful "paraplegic" marriages and they seem to be working out smoothly. Marriage involves sympathetic understanding by both partners. The two must operate as a team and, in a house which is adapted to wheel-chair life, this is not too hard. If the matter of marriage is approached intelligently, the chances for happiness are very high.

In the final analysis, the business of

mental readjustment is set up to the man himself. He can be provided with medical treatment, re-training and vocational training, but unless he is prepared to fight it out and establish himself, none of these facilities will help him. It would be false to say that life in a wheel-chair is all sweetness and light — nothing is farther from the truth. But the fact remains that there is still a very great deal to live for and the paraplegic does not have to look very far for it. Living on wheels is a challenge to every individual faced with complete paraplegia — a challenge to his moral strength, ingenuity, and sense of humor. After his first few months out of the hospital, he will probably find that the challenge was not nearly so formidable as he thought.

Meal Planning and Preparation

H. RUTH CRAWFORD

It has been said that "a good diet may add not only years to one's life but life to one's years." Fortunately, we have available in Canada today a very abundant variety of nutritious foods, within the scope of almost every budget. How best to combine these foods into pleasing, nourishing meals is a problem which confronts almost every nurse whether she be giving advice on meal planning to others, keeping house for herself, or just choosing meals each day from a restaurant menu.

In planning meals, there are three points to keep in mind: the adequacy of the meal, its limitations due to available money and facilities, and its attractiveness, or appetite appeal.

ADEQUACY OF THE MEAL

The adequacy of the meal is, of course, of prime importance, and each day's menu should be planned to include the required food nutrients: calories, protein, minerals,

and vitamins in adequate amount.

This can be accomplished quite easily if the following foods, in the amounts indicated, are used daily:

Milk: Adults, half-pint; children, at least 1 pint. Some cheese as available.

Fruit: One serving of citrus fruit or tomatoes or their juices. One serving of other fruit, fresh or cooked.

Vegetables: One serving of potatoes. Two servings of other vegetables, frequently raw.

Cereals and bread: One serving of wholegrain cereal. Four to six slices of bread, preferably whole-wheat.

Meat and fish: One serving of meat, fish or meat substitute. Liver, heart or kidney once a week.

Eggs: Three to four per week.

A source of *vitamin D*, such as cod liver oil, is needed by all growing children.

Iodized salt.

Low Cost Diets

If one stops to analyse the distribution of the food dollar necessary to purchase the food listed above, it will become apparent that the dollar is split into four almost equal parts for:

- 1. Milk and milk products.
- 2. Meat, fish and eggs.
- 3. Vegetables and fruits.
- 4. Cereals, bread, sugar, and extras.

When it is necessary to severely restrict the amount of money spent on food, certain changes will be necessary in this distribution of the food dollar. The chief change will be an increase in the amount of money spent on cereals and bread, for this group supplies great over-all food value for little money. At the same time there will be a decrease in the amount of money spent on meat and eggs, which are among the most expensive items listed. Fewer, and also cheaper, cuts of meat will be purchased. These cuts require long, slow cooking in moist heat, but if properly done are fully as tender, flavorful, and nutritious as more expensive cuts. Cheese should be included in generous amounts in all low cost diets, for it is a good meat substitute and quite inexpensive.

"Eat what you should, then what

you would" is a good rule to remember. The health-giving, protective foods should be purchased with certainty before any money is spent on such expensive and non-essential foods as cake, pastries, candy, and soft drinks. A great many diets are poor and inadequate not because there is too little money available, but because too large a proportion of the food dollar is spent on these non-essential sweet foods, which at the same time are harmful to teeth and dull the appetite for more healthful foods. Low cost meals can be planned to meet the daily nutritional needs fully as well as more costly ones. A large amount of money spent for food does not guarantee better nutrition, and may only buy a greater variety of more expensive and outof-season foods.

VARIETY

Regardless of the amount of money spent on food, however, the meal should be so carefully planned and served that eating it is a pleasure, not a mere necessity. This is of particular importance in families with young children where getting them to

SAMPLE MENUS

At all meals, serve: whole-wheat bread and butter, coffee or tea for adults, milk for children.

Breakfast

Citrus fruit or juice or tomato juice Cooked whole-grain cereal with top milk Toast or muffin (Bacon, eggs, or fish may be added.)

Dinner

Pot roast of beef Browned potatoes Spinach Raw carrot sticks Baked apple

Supper or Luncheon

Cream of tomato soup Chopped egg and lettuce sandwiches Grape sponge

Baked stuffed heart with gravy
Mashed potatoes Carrots
Celery curls

Chocolate blanc mange

Macaroni and cheese Tossed green vegetable salad Fruit cup Bran muttins

Meat pie with biscuit top
Baked potatoes Green peas
Stewed rhubarb

Scrambled eggs with tomato sauce Cole slaw Butterscotch pudding eat all the food that is served them may be a frequent problem. A keyword in attractive meal planning is variety. First, of course, there should be variety of foods, as already mentioned. Then these foods should be so chosen that they provide a pleasing variety of colour and texture. How much more appetizing is a plate of scrambled eggs, green peas, and carrot sticks, than one of macaroni and potato salad! Not only is it more colourful, but also more interesting in texture, a point which is often overlooked. Crisp, raw vegetables served along with a soft, smoothtextured food can add much to its enjoyment and, of course, to its food value. In addition, many children will eat various vegetables raw, while refusing to eat them when cooked. This combination of raw vegetables and a hot dish also provides another variety in our meal: that of hot and cold foods. nurse who has lived in residence hardly needs to be told of the desirability of also providing variety in choice of foods on similar days from week to week. Too many meal planners lapse into the habit of serving roast beef and pie every Sunday, cold roast on Monday, fish on Friday, and so on.

In planning meals, a little imagination and ingenuity are indispensable. To know a variety of ways of serving the same foods will add new interest at meal-time. For instance, the leftover portion of a roast of beef may be used in a number of interesting ways on succeeding days, such as in shepherd's pie, browned hash, and scallop of meat and eggs. Potatoes, when served mashed day after day, completely lose their interest. Actually there are at least fifteen different ways that they may be prepared: pan-fried, baked, creamed, roasted, and scalloped to mention only a few. The alert menu-planner realizes that variety is truly the spice of food as well as life.

FOOD VALUES

Nurses in the field of public health may sometimes recommend certain needed foods to a family, only to find that these foods are either unavailable or strongly disliked. In such circumstances, some knowledge of *food values* is necessary before substitute foods can be suggested. The following list of foods which are best sources of the various nutrients may be of assistance in this connection. Foods are listed in order of content per serving:

Protein: Meat, fish, fowl, cheese, dried beans and peas, eggs, milk.

Calcium: Milk, cheese.

Iron: Liver, meat, dried beans and peas, green leafy vegetables, eggs, whole-grain products.

Vitamin A: Green, leafy, and yellow vegetables, liver, milk.

Thiamine (B_1) : Pork, other meat, whole grain products, dried beans and peas, eggs.

Ascorbic acid (C): Citrus fruit, tomato juice, cabbage and other vegetables.

Riboflavin (B_2) : Liver, milk, meat, eggs, cheese.

COOKING METHODS

The proof of the pudding is in the eating, and along with skilful meal planning must go good cooking methods. Vegetables are among the foods most abused by common cooking procedures. For best flavor and nutrient retention, they should be peeled or brushed just before cooking, placed in just enough boiling water to cover, and cooked until just tender. The left-over vegetable water contains some of the water-soluble vitamins and should be used for flavoring All meat soups, sauces or gravy. is more tender and juicy with less shrinkage if it is cooked slowly at a low temperature. The cheaper, tougher cuts of meat should be cooked in moist heat, such as that obtained by braising or simmering with a little water, in a covered pan. Fruit, when cooked, is steamed, baked, or simmered very slowly in a small amount of water, to minimize vitamin destruction.

The planning and preparation of family meals is a daily task that is performed with more varying degrees of success, perhaps, than any other. Careful surveys of family dietary

habits show that when meals are found to be inadequate, it is frequently a lack of nutritional information and indifference on the part of the homemaker that is responsible. This situation presents to the public health nurse a challenge which she cannot fail to accept.

Role of Pathology in Cancer Control

JOHN E. KURTZ, M.D.

CANCER is just as much a scourge as and a greater killer of mankind than Naziism. It will require an allout effort of scientific and social forces to provide a foundation for a successful attack on this insidious and deadly enemy. The problem is so complex that only since close cooperation and organization of all medical branches and basic sciences has significant progress in cancer research and control resulted.

Pathology is a branch of medicine concerned with the origin and development of disease as well as with the structural and functional tissue responses to specific disease processes. Its growth as a science has been closely linked with the development of our knowledge of cancer. At the present time, as well as in the past, the pathologist has an important place in a cancer con-

trol program.

Although tumor growths have been recognized for ages it was not until the nineteenth century that fundamental knowledge of their characteristics and structure was acquired. The first tremendous step was development of the microscope, providing means for the first time to study tissues minutely. Discovery of the cell as the unit structure of tissue was followed shortly by publication of Virchow's monumental work "Cellular Pathology" in the middle of the nineteenth century. The purely clinical approach to medical problems gave way to the pathologic-anatomical attitudes, and this new concept produced rapid strides not only in the study of cancer but in the whole of medicine. One of the first fundamental observations was the separation of benign from malignant tumor growths on the basis of cellular changes. Most of the work since then has been concerned with the separation of tumor types according to their cellular characteristics and correlating of this with the rapidity of growth, mode and likelihood of spread, response to various forms of treatment and the usual termination. This period just ending has merged into a new era of experimental production of cancer in the laboratory and chemical study of cellular metabolism. Pathology today, a firmly established medical specialty, approaches an exact laboratory science, but at the same time contributes to the diagnosis, prognosis, and treatment of most cancer patients.

The pathologist, in formulating basic concepts of disease, examines post-mortem and surgical pathological material in the light of the patient's history, clinical course, treatment, and subsequent outcome. Progress has come through the study and publication of findings from series of patients. Every department of pathology in the medical schools and every hospital laboratory contributes to our knowledge of cancer. Some of the most significant studies have come from such places as the United States Institute of Pathology in Washington, D.C., where tremendous amounts of material are collected from the entire world and analyzed by leading pathologists. Canada, recognizing the value of this approach, has just organized its own Cancer Institute.

Although some of the basic ex-

perimental work has passed out of the pathologist's hands since chemical compounds and ultra-microscopic structures have become increasingly important, he stands in a unique position to correlate research findings with the individual cancer patient in the hospital. Many observations in experimental biology, chemistry, and physics are not intended for direct application to clinical work, but later find a definite place in the study, diagnosis, and treatment of tumor growths. Examples of these are synthesis of carcinogenic agents by the chemists, growth of human tissues in artificial media, and application of x-ray and radio-active material to the treatment of cancer. After tar had been definitely established as a carcinogenic agent in the production of both human and animal carcinoma, it was discovered that related chemical compounds, synthesized previously by the chemists, were still more potent in experimental cancer production. has been only recently that human tissues could be grown and studied outside of the body. Practical pathologic application of these accomplishments are becoming more numerous. In some tumors the cells and structures are so atypical that exact classification by histologic examination is impossible, but by the study of tissue cultures on media the original source of the tumor may become apparent. In the field of radiation therapy pathology has been of extreme value. first in evaluating effects of radiation on normal and tumor tissues and. secondly, in determining results of cancer treatment. Frequently, after all external evidence of tumor growth has disappeared following radiation therapy, microscopic study of the area reveals cancer cells lurking in tissue depths. With opening of the atomic age, radio-active materials are available for cancer research, particularly in the realm of treat-Cellular responses to these new radio-active substances are evidenced only by microscopic study of irradiated tissues.

Education of the clinician to the pathologic anatomic approach to

medical problems is an important part of medical education. Undergraduates as well as graduate students are well grounded in fundamental principles and a good grasp of pathology is required for certification in the medical specialties. General characteristics of tumors and a study of individual tumors comprise an extensive part of the undergraduate pathology course. A surgeon must be a gross pathologist in his own right, particularly in cancer surgery, for success or failure of the operation depends upon complete eradication, not only of a primary growth but also the neighboring foci of metastases. Post-mortem examination and adequate surgical material here again are absolutely necessary, not only for formation of the student's fundamental knowledge, but also from the clinician's standpoint to correlate the diagnosis and effect of treatment in view of the pathologic findings. It is only by the critical examination of such material by the clinician as well as the pathologist that diagnosis becomes more accurate and treatment has its maximum effectiveness.

The practising hospital pathologist, although he usually has little direct contact with the patient, plays definite part in the diagnosis and handling of cancer patients. He has often been called the "doctors" doctor" because he reports his findings to the doctor, submitting the specimen or securing the autopsy, but he still has an intense appreciation of his responsibility to the individual patient. Microscopic and gross study of tumors constitutes the most important and numerous of the surgical specimens coming to him for examination and diagnosis. His most vital problems are distinguishing between benign and malignant growths, determining the specific type of tumor, and judging the extent of spread from the material submitted to him by the surgeon. It is a heavy responsibility and at times most difficult to make definite distinctions between cancer and inflammation. Results of treatment in cancer depend upon early re-

cognition while the lesion is still localized, and early indications of malignancy may consist only of microscopic local cell changes. of the tissue removed in the operating-room is sent to the laboratory for pathologic diagnosis and small pieces of tissue called biopsies are frequently taken from suspicious lesions for diagnosis before further procedure. A report of cancer to the surgeon or radiologist may be the basis for future treatment and, if the lesion is early, the fate of the patient rests on a correct diagnosis. The pathologist's assistance in the handling of a cancer case may best be illustrated by an example: A woman in her late 30's presents herself to a surgeon with a freely movable, painless lump in the Clinically the differential diagnosis lies between early carcinoma, a cyst or a benign fibrous tissue growth called a fibroadenoma. the basis of past experience, most surgeons wish to operate and remove the lump as quickly as possible. pathologist is present in the operating-room at the time of removal and sees the cut surface of the excised lesion with the surgeon. The diagnosis can frequently be made on this examination, but in certain cases a positive diagnosis can not be determined gross-The pathologist quick-freezes a bit of the tissue, cuts a microscopically thin slice, stains it, and examines the tissue under a microscope. This procedure, taking only a few minutes, is done while the patient is still under the anesthetic and further operative procedure is usually deferred until the pathologist reports his findings. Whatever the verdict. whether benign or malignant, the

surgeon can then proceed with the assurance of a definite diagnosis. If the growth is malignant the breast is removed together with the fat and lymph nodes from the axillary The pathologist, by his study of the removed breast and the material from the armpit, determines the extent of local spread as well as the possibility of distant growth. Permanent microscopic sections made in the laboratory are filed, and a report of the findings is sent to the surgeon and incorporated in the patient's chart. In case of further developments, this information is available to the clinician as well as the pathologist for further study. As can well be seen post-operative radiation therapy frequently depends upon the pathologist's opinion. The pathologist then is of tremendous aid to the clinician in the early recognition and in the decision of the most effective treatment.

It is the cancer patient's right to expect all the facilities of modern medicine to be available in the early recognition of his disease in the curable phase, and adequate surgical or radiological treatment to ensure the best possible results. A well-conducted program of pathological research and education, as well as adequate hospital laboratories supervised by a competent pathologist, are essential in cancer control. This is important for the clinician to help him evaluate the individual patient's tumor growth, extent of spread, and to determine the most efficacious form of treatment. For the patient, it may play an important part in the early recognition and cure of an otherwise hopeless condition.

Dollars for Books

Slowly but surely the dollars are rolling in for the War Memorial Trust Fund. The Executive Committee of the Canadian Nurses' Association discussed the project at its recent meeting. They agreed that their had not been sufficient time to permit all provinces to reach the minimum objectives set last December. The decision was made to extend the campaign to the end of the year

Several provinces report that their collections to date are over 50 per cent of the original objective. Commencing with the next issue of the *Journal*, and each month thereafter, the cumulative totals for each province will be published. In the meantime, it is planned to begin the assembling of libraries with the

funds now available and to send complete library units to certain of the devastated countries. Other such units will be prepared as rapidly as the money comes in.

If you have not already made your donation, send it to the office of the Registered Nurses' Association right away. Refer to the Official Directory for the name and address of the executive secretary of your provincial association.

The purpose of this campaign was unanimously assented to at the biennial convention in Toronto last summer — to honor all nursing sisters who served in World War II. They are themselves giving active support to the Fund both individually and through the branches of the Nursing Sisters' Association. Can we do less? Give your dollars to purchase books for the use of our colleagues in distant, devastated lands.

Burns and Scalds

Burns and scalds are the most frequent type of fatal accident in the kitchen. These injuries, it is estimated, take the lives of more than two thousand people a year in our country, or roughly one-third of all the lives lost in the kitchen mishaps. This figure is exclusive of several hundred persons a year who perish in homes that are either partially or totally destroyed by conflagrations which start in the kitchen. Many more women than men are fatally burned in the kitchen. The reasons for this sex difference are rather obvious. Not only does the woman spend a large proportion of her time in the kitchen and around the stove, but also her clothing is a much greater fire hazard than the man's, being looser-fitting and frequently of highly inflammable material.

Scalds suffered in the kitchen account for a relatively large number of deaths annually among young children. In many of these instances the child, while playing about the kitchen, falls into a pail or some other container of scalding fluid that is left standing on the floor. A number of youngsters each year are fatally scalded when they bring down upon themselves a pot of tea, a plate of soup, or some other hot substance being served on the table. Others are scalded by pulling down from the stove hot fluids in a pot or pan with its handle protruding.

- Statistical Bulletin.

Cape Wanted

Last December we carried the story of Mary Peters' return to the mission fields in China on our "Interesting People" page. The following letter has just been received from her. We hope that there is a nurse who will send the cape which she is no longer using:

"I wonder if you will insert a request in The Canadian Nurse for a nurse's second-hand cape needed by a missionary nurse in China who, when she thought she could not return to her work, sent her own cape over to England during the war for a nurse who might need it worse than she. Perhaps some nurse who has no further use for her cape may see this notice.

"I should prefer a long cape rather than a short length as it is cold during our service in the early morning with no heat in the chapel. I need only one cape, of course, and shall be so grateful if that could be found and sent before August to Mrs. W. G. Tamblyn, 67 Roxborough Drive, Toronto 5, Ontario.

"I am looking forward so much to having that cape before the winter!"

The Red Cross in Japan

The Japanese Red Cross has been reorganized and will once more put its humanitarian activities at the disposal of the Japanese population. These activities are: Health service, training of nurses, first aid courses, supply of staff for clinics, establishment of sanatoria, first aid posts on sea beaches and river banks, highway first aid posts, Junior Red Cross movements in all schools, relief work in case of calamity, and other voluntary services.

Among the principal tasks to be undertaken is the training of nurses, who will serve not only in time of war or natural calamity, but also in hospitals, clinics, and sanatoria. The Japanese Red Cross, anxious to raise the standard of training of the nurses in its hospitals, has organized, in co-operation with St. Luke's School of Nursing, a new course at the Japanese Central Red Cross Hospital. Another institution, once known as the Central School for Nurses, has recently been authorized to establish itself as an accredited school of nursing.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

An Orientation Program

NOREEN D. LAMBERT

Why is there a need for an orientation program? Let us answer this question with a more pertinent one: "Have you ever taken a position in a new hospital with no explanation of your duties or the location of your ward?" This has occurred and the resultant problems will be only too readily admitted.

If the graduate is to attain a reasonable sense of security in a new position, it is up to some delegated personnel of the hospital to plan a well-integrated orientation program. It is the opinion of the writer that the nursing school staff, particularly the nursing arts instructor, could play an active part in such a plan. Certainly the time spent in introducing the new graduate will be returned a hundred-fold by her adjustment to the new situation.

When a nurse applies for a position a request for a personal interview with the director of nurses is important. This is the first step to acquaint her with those to whom she will be responsible. In turn it provides the interviewer an opportunity to judge the personality and temperament of the applicant, thereby foreseeing any problems of placement which may possibly arise in her association with other members of the staff. If there is a leaflet with an outline of regulations for the graduate staff it may be given to the applicant at this time. Otherwise, rules regarding laundry, time-book, meal tickets, etc., should be outlined verbally.

On the morning the new graduate reports for duty, or perhaps the day before, the director of nurses or her assistant meets her and introduces her to the nursing school staff. She is taken on a tour of the hospital by a member of this staff. At this time, she is introduced to the heads of departments, including special departments, so that the way is paved for further contact with their personnel. At the end of the tour, the new member is taken to her assigned station, and there introduced to the head of this department. A careful and thorough initiation into the geography of the floor follows, showing her how rooms are lettered and numbered, making use of an empty ward, if possible, to point out details of arrangement and signal system.

The location and use of standard equipment of the ward are discussed, such as: (1) linen-room and linen supply; (2) utility-room and its equipment; (3) treatment rooms; (4) sterile supplies and dressing-carriage; if there is a central dressing-room, procedure for obtaining supplies is explained; (5) various ward keys and regulations; (6) fire equipment and precautions; (7) ward library and its regulations.

Included in this orientation is an explanation of the method of administering medicines, hypodermic trays and the technique employed, the ordering of drugs and the rules governing narcotics.

At the charting desk, the new

JUNE, 1947

member is introduced to the record system. A model chart is demonstrated thus ensuring a correct impression. The doctor's order book is desscribed, as well as the treatment sheet with daily, standing, or specific orders. Requisition and treatment slips are shown, and special details here pointed out.

It is advisable for each department to have a procedure book in the ward library, affording a means of quick reference for students and graduate nurses. As it is felt that the graduate nurse on staff is an essential figure in the teaching of student nurses, she is expected to adopt the procedures of the hospital in which she works. The procedures of one hospital are not considered better than those of another, but there is a recognized need for uniformity in an institution where there is a nursing Needless to say, graduate nurses must be flexible in their ability to adjust, accompanied by an open mind to accept various procedures without the sacrificing of principles.

The supervisor of the ward outlines the assignment of patients and a brief history of those who will be her special charge, with a description of the routine care of patients. Following this theoretical introduction, the new member is introduced to her

patients.

The usual succession of events on the ward has an essential place in the orientation pattern. This includes time for trays, baths, doctors' visits, out-patient clinics, bed-pans, visiting hours, rest hours, afternoon and evening care of patients.

Special regulations with regard to time sheets, breakage of equipment, care of soiled, stained, and torn linen, procedure for admission and discharge of patients, will differ in each locale thus requiring complete knowledge by each new member of the staff.

After the new graduate has been working for three or four days, allowing time for a general adjustment, she spends a two- to three-hour period with the nursing arts instructor.

Enemas, douches, catheterizations, intravenous, and other treatments deemed necessary by the instructor are demonstrated. At the same time the instructor may go over the ward teaching program and its integration with classroom instruction.

Consideration must be given to the private duty nurse and her place in an initiation scheme. She merits a warm reception by supervisor and students, for her appearance on a ward allays many worries of a very ill patient. She requires an explanation of the ward, its equipment and regulations, relations with other departments, records, day and night reports, medicine closet, and various procedures. However, the time spent with the private duty nurse will be more limited because of the patient's immediate need of her services. Nevertheless, the efficiency of a private nurse is a very real responsibility of the supervisor and head nurse of a department where she works.

If a new member to a staff is launched upon her tasks by means of such a program, the feeling of "belonging," which is an essential component of good morale, will be initiated from the beginning. There will be better co-operation between doctor, supervisor, staff members, and patients. It will help her to develop new insight and understanding, making her adjustment to the new

service more promising.

One department reflecting harmony between all personnel will foster confidence in all who are associated with its functioning. In the words of Ernie Pyle, writing of a unit in North Africa: "The whole outfit vibrated with accomplishment, and they were all proud together."

BIBLIOGRAPHY

- Hansen, Helen F. Professional Relationships of the Nurse. McAinsh & Co. Ltd., Toronto.
- 2. American Journal of Nursing. May 1940, Vol. 40, No. 5; Dec. 1943, Vol. 43, No. 12
- Wayland, McManus and Faddis. The Hospital Head Nurse. The Macmillan Co. of Canada Ltd., Toronto.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

They Too Are Our Patients

PEARL STIVER

Syphilis and gonorrhea are communicable diseases. Since we, in public health nursing, are vitally concerned with the control of all communicable diseases it would reasonably follow that we are interested in the control of syphilis and gonorrhea.

As public health nurses we are not only interested in our patients — we are also interested in their homes and in their relationships in these homes. Our interest in the patient is deepened then when we know that he has syphilis or gonorrhea, for we realize that these diseases more than any other illness affect every phase of the patient's life—home, business, and social relationships.

Ordinarily, when an individual becomes ill, he or she receives the attention of the entire family. Sympathy and every consideration is given. What a different situation if the individual develops syphilis or gonorrhea! She must not tell father or he would put her out. Mother would be heartbroken. Family and friends would despise her. Even the community views the syphilis or gonorrhea patient in much the same light as does the family.

At work the patient is faced with another grave problem, namely, that of losing his job. Recently one young man was discharged from work because of a positive blood test found in his pre-employment examination. He obtained another position. When he was given an appointment for a

physical examination with his new firm, in desperation the boy appealed to the Health Department. Must he again be thrown out of work? The syphilis or gonorrhea patient, frowned on by family, an outcast of society, is faced with the problem of insecurity in his or her work.

How then can we, as public health nurses, assist these bewildered individuals? If we are to be of real help, two definite steps must be taken:

- 1. A critical examinaton of our own attitudes.
- 2. An interested study of our patient, his environment, and his relationships.

OUR OWN ATTITUDE

What is our attitude toward the syphilis or gonorrhea patient? Is he to us the same as any other patient or do we feel that he is reaping the just reward of his sins? Our patients are extremely sensitive to our atti-Therefore, unless we can regard syphilis and gonorrhea in the same light as we do any other communicable disease and unless we can objectively, and with understanding, discuss venereal diseases with our patients, our efforts will avail little. To gain this understanding of our patient we must know something about him, the kind of home he comes from, his relationships in that home, with his friends, in his work. brief, if we are to help him, we must endeavor to find the underlying factors, the real causes of his in-

JUNE, 1947 443

fection. Why has he chosen this pattern of behavior? How did he get off on the wrong foot in the first place?

From our study of mental hygiene we know that an individual responds to a situation because of what he is, that is, what he has been born with and the effect of his environment and the various circumstances which have surrounded his life. Therefore, when we study our patients we interpret their response to a certain situation in the light of those things which have gone into the making of their total personality.

Now if we approach our syphilis or gonorrhea patient with this attitude, can we continue to feel that he or she is just plain bad? To illustrate,

could we consider one case:

Mary, 15 years of age, was reported to us as a contact of gonorrhea. Because of the girl's age it was necessary to contact the parents. When the nurse telephoned the mother to make an appointment to see her, the mother replied, "If it's about Mary and it's trouble, I don't want to hear it."

Arrangements were duly made for Mary's examination and she was found to be positive for gonorrhea. The complete history as taken by the nurse is as follows:

Mary, elder of two children, has a brother twelve years of age. Her father is a sea captain, apparently the more stable and intelligent parent, twelve years older than the mother. The mother appears below average intelligence, works in a laundry. In the home is the maternal grandmother of an unstable type, domineering, who "rules the roost." The mother goes out to dances a lot, presumably to get away from the nagging grandmother. The home is a poor one, consisting of three rooms in a poor district of a large urban centre.

Mary is a clean, tidy, attractive girl attending high school. She has made few friends in school because she feels inferior to the other students. Her only real associates are the childrn on the street in her own community. She admits sexual exposure with two of these boys whom she has known for years. An attractive girl of normal intelligence, ashamed of her own home and family,

she is obviously seeking an escape. Her life has been one of insecurity, instability, devoid of affection and understanding. She has doubtless given in to the boys because they seemed to show her sympathy and affection which she had not previously known.

Can we blame Mary for her behavior? What an entirely different picture than if we considered Mary only in the light of the original information — a fifteen-year-old girl, positive for gonorrhea, admits sex relations with two different boys.

As we delve into the history of many of these patients we many times wonder how they are as nice as they are. We do not condone their behavior but we should seek to understand. It is then, and only then, that we shall be in a position to help them.

THE ART OF INTERVIEWING

Since the medium through which we gain information, which enables us to understand the patient and subsequently to help him, is the interview, it is important that we as public health nurses be skilled in this art. Interviewing implies infinitely more than the asking of certain questions and the writing down of the answers on a given form. It implies the establishing of rapport, the gaining of the patient's confidence, the asking of cardinal questions which lead the patient to tell his problem and state his personal experiences. It embodies the gaining of confidence, the art of skilful questioning, the ability to listen, interjecting the occasional pertinent comment which leads the patient on. The successful interviewer considers even the minor details, such as, the place of the interview, the position of the patient and of the nurse. For example, to talk across a desk is talking "to," to have the patient on the same side of the desk is talking "with." These points may seem incidental and trivial; nevertheless anything which strengthens our relationship with the patient promotes mutual confidence.

Upon our ability to interview depends the success of our work. If we cannot gain our patient's confi-

dence and stimulate him to talk, we cannot understand him. If we do not understand him we cannot help him meet and solve his own problem which, after all, is our ultimate objective in all public health work.

The days when we, as public health nurses, did not concern ourselves with the syphilis and gonor-rhea patient are gone. Venereal diseases present a health problem in every community and a threat to individual and family health and

happiness.

The removal of prejudice and ignorance, which has hindered venereal disease control programs for so long, indicates interest and concern on the part of individuals and commun-It places greater responsiities. bility upon us as nurses. are now willing to discuss syphilis and gonorrhea in an objective way. They have many questions. They seek leadership in any endeavor to stamp out these diseases. Naturally they turn to us for help and guidance. We have a responsibility not only as professional workers but as interested citizens. To discharge our duties constructively we need not only a knowledge of syphilis and gonorrhea but as well an understanding of the individuals who suffer from these diseases.

CASE RECORD

The problems of the patient with venereal disease and the way in which assistance may be provided is illustrated in the following case record:

A young married couple appeared at one of our clinics with gonorrhea. When interviewed by the public health nurse regarding contacts, the husband gave the wife's name, and the wife named her husband. Each were re-interviewed with the same results. Finally the nurse asked to see the husband again. Taking him into her office, closing the door, and seating him comfortably, the nurse assured the patient that all information obtained from patients is professionally confidential. The nurse continued:

"Now, Mr. A, we have talked with you on two different occasions, and also with your wife as to where this infection may

have come from. You both maintain that you have been exposed to no one else. Now I've thought this thing through rather carefully and somehow I'm inclined to believe your wife."

The man, somewhat fussed but not annoyed, replied, "Nurse, if I tell you the truth you'll never tell my wife? Well, I got sore at her one night and went out and picked up a girl and this is the result."

In course of conversation the nurse inquired, "Tell me, how are you getting along with your wife?" The patient replied, "That's the trouble, I'm not." "Do you love your wife or do you feel you would like someone else?" the nurse inquired.

"Of course I love my wife and I do not want anyone else, but she nags me and nearly drives me crazy. That's what happened that night."

The nurse let the patient talk on. Finally she said, "Would you like me to talk with your wife? It may not help. On the other hand, it may." The patient agreed, provided the nurse did not mention this conversation. He was again reassured.

The nurse visited the wife in her home. In the course of conversation, she inquired how the wife and her husband were getting along. The wife replied, "Oh, all right."

"Tell me," said the nurse, referring to their infection, "do you ever mention this to him?"

Rather guiltily the wife replied, "Oh, sometimes, in fun."

The nurse continued: "I wouldn't if I were you. It really isn't funny, is it? Certainly it isn't funny to you and I'm sure it isn't to your husband. You know, we can cure your infection but if you break up your home we can do nothing about that. You have a nice home, a nice family. Your husband has a good job. You love him and your children and I'm sure he feels the same. We all know how hard it is to put up with nagging and having our faults and failures repeated to us. Often little things can do so much harm. Let me assure you we are going to see you through this illness, but remember, your home depends on you."

Both husband and wife continued regularly with treatment. Some time later the husband came to the clinic and asked to see the nurse. When seated in her office, he said, "Nurse, I don't know what you said to my wife, but boy! — she's wonderful! We're getting along swell and everything going fine."

Like all other public health problems, venereal disease has a basic cause and predisposing factors. Syphilis and gonorrhea constitute a great public health problem, threatening the very foundations of family life. As public health nurses, whose interest is the strengthening of the home by the procurement of the optimum of health for every member of the family, we cannot ignore our responsibilities. Sufferers of syphilis and gonorrhea need help.

They, too, are our patients!

Nursing with UNRRA in Greece

MARY E. HENDERSON

I HAVE just returned from over two years' service with the United Nations Relief and Rehabilitation Administration of which nineteen months were spent in Greece. Canadian nurses would probably be interested in hearing something of nursing conditions in this country.

UNRRA's work in Greece embraced many phases of relief and rehabilitation in various fields, such as health, welfare, food, agriculture, fisheries, industrial rehabilitation, displaced persons, etc. In general, this work was largely of an advisory nature, the aim being to help the Greek people to re-establish their services on the pre-war level. All divisions in UNRRA worked very closely with corresponding government departments and great difficulties resulted from the frequent changes of government. In the two years that have elapsed since the liberation of Greece from German domination there have been nine different governments.

Here I shall attempt to give only a brief description of the work in our own field of nursing, followed by some general impressions of Greece. Nursing was only one of the various sections comprising the Health Division of UNRRA, others being nutrition, sanitation, tuberculosis, laboratories, medical supplies, and rehabilitation of the disabled. Among the greatest health problems in Greece are malaria, tuberculosis, and enteric and gastrointestinal diseases. The UNRRA Tuberculosis Consultant estimated that the tuberculosis incidence in Greece today is at least twelve to fourteen times greater than it is in either Great Britain or the United States. The malaria incidence has always been very high. It is grati-fying to know, however, that the tuberculosis and malaria control work have been stimulated very effectively through the influence of the UNRRA tuberculosis and sanitation sections. Trachoma is another prevalent disease in Greece while typhoid fever is endemic. There is also a considerable amount of malnutrition, which is especially noticeable among the children. One is struck by the number of cripples one sees in Greece, both on city streets and in rural villages, for, added to the considerable number of disabilities caused by disease, numerous people have been crippled due to war injuries and exploding mines.

For the purpose of the administration of the work UNRRA divided Greece into eleven regions. nursing personnel in each region consisted of a nursing consultant and a staff of public health and hospital nursing advisers, the number depending on the size of the region. The UNRRA nurses worked mainly in an advisory and educational capacity with the Greek personnel in the existing health organizations and hospitals. The chief problem in the nursing field is the great shortage of graduate nurses, there being only five hundred in the whole of Greece to serve a population of approximately seven million. It should be

(Continued on page 467)

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Infirmière et la Culture Générale

GEORGES HEBERT, M.D.

La profession d'infirmière évolue avec une rapidité étonnante depuis quelques années. Voyons un peu les modifications apportées dans les programmes d'études et disons ensuite quelques mots sur la culture générale nécessaire à l'infirmière de l'avenir.

Modifications dans les pro-GRAMMES D'ETUDES

Sous la directive des associations d'infirmières enregistrées, les écoles de gardes-malades ont progressivement exigé de leurs aspirantes un degré plus élevé d'instruction. Ne peut être acceptée actuellement que la porteuse d'un certificat de onzième année scolaire.

Le niveau de la profession y a sûrement gagné; je me souviens en effet de la correction des examens des infirmières vers 1934. Les fautes d'orthographe qu'on y rencontrait étaient simplement monstrueuses. Je n'exagère pas en affirmant que le pourcentage des copies cousues de fautes dépassait de beaucoup celui des feuilles sans erreur orthographique. Moins précipité par la vie, il m'arrivait souvent alors de corriger au crayon rouge chacune de ces fautes!

Loin de moi la pensée qu'il n'existât à cette époque des jeunes filles fort instruites dont les examens pussent se comparer avec les meilleurs d'aujour-d'hui! A celles-là je rends hommage et c'est probablement grâce à leur exemple, leur initiative et leur travail qu'on a pu réaliser les progrès actuels. Elles ont été des devancières et nous leur devons tous une sincère reconnaissance. Par elles, la voie a été tracée.

Le résultat se constate de lui-même; nous ne sommes plus horripilés par les fautes d'orthographe; bien au contraire, nous pouvons, lors de la correction des examens, apprécier les phrases élégantes et bien construites.

En causant avec les infirmières nous réalisons qu'avec le niveau d'instruction s'est élevé aussi celui de la bonne éducation. Il nous arrive très souvent de rencontrer parmi elles des jeunes filles issues de milieux intellectuels très bien cotés et de découvrir dans leur personalité le raffinement d'une éducation très délicate. Nul doute qu'une instruction plus solide n'ait conduit à une plus grande distinction dans les manières. Cela va de soi. Qu'il y ait des exceptions, nous en convenons, mais en général il faut l'admettre, les gens plus cultivés ont une éducation plus subtile. Cette éducation sera d'autant plus raffinée qu'elle remonte à un plus grand nombre de générations. Et ceci, jusqu'au jour où un individu fait mentir la loi de la famille! Il devient alors une exception mais ne change rien à la règle.

Revenons à nos écoles d'infirmières. Depuis que fut adopté le principe d'un minimum d'instruction correspondant à la onzième année scolaire, un programme d'études médicales plus étendues fut mis en vigueur. Les notions de physiologie, de bactériologie et de pathologie sont augmentées. On pousse les études jusque dans le giron des spécialités. En somme, les écoles d'infirmières suivent le progrès scien-

Je dirais même: elles sont devenues si scientifiques que bientôt elles au-

IUNE, 1947

ront oublié totalement le but pour lequel elles ont été créées à savoir le soin

immédiat des malades!

Plus en effet on s'élève dans les sphères de l'intellect moins on aime à pratiquer le travail manuel. Vous en trouverez chaque jour des exemples dans la vie féminine. Les grandes dames instruites, bachelières ès-art, avocats, médecins, etc., n'ont plus dans leurs maisons, le même intérêt qu'avaient leurs mères ou leurs grand'mères à épousseter, balayer, laver et repasser. Leur esprit de devoir les invite à faire ces travaux fastidieux mais, dans leur for intérieur, elles souffrent et leur légitime ambition est de trouver les aides-ménagères qui feront ce travail pendant qu'elles s'occuperont de science et d'art.

Le soin immédiat des malades requiert en général beaucoup de travail manuel. Il faut baigner le malade, l'installer dans des oreillers profonds, le faire manger, lui procurer des soins fort intimes. Une fois cette tâche terminée, commence le travail intellectuel, celui où la science est nécessaire et où la psychologie est indispensable. A peine l'infirmière s'est elle adonnée à cette partie intéressante de sa tâche qu'il faut de nouveau recommencer

le travail terre à terre.

Cette dernière partie du devoir des infirmières demande de la patience, du dévouement et un coeur généreux. Il n'exige pas de connaissances scientifiques. Dans de telles circonstances, pourquoi les écoles d'infirmières chercheraient-elles tant à élever le niveau intellectuel de leurs élèves? Ne seraitce pas un tort de vouloir le faire? Risquant de s'éloigner des soins matériels du malade, ne ferait-on pas fausse route?

Cette question a fait l'objet des réflexions de nombreux médecins — non des moindres — et sûrement du public. Souvent même en voyant s'approcher de leur lit des infirmières suprêmement élégantes, raffinées et distinguées, des malades ont cru qu'ils n'oseraient jamais demander à de telles jeunes filles les services requis par leur état. Peu à peu cependant, devant la nécessité et la sympathie réelle du coeur généreux de la garde-

malade ils ont accepté ses soins dévoués. Ce fut une révélation! Ils découvraient dans le monde l'existence de coeurs si profondement humains qu'on se demande s'il n'y a pas

un peu de divin en eux.

Et bien, ces personnes exceptionnelles yivent actuellement dans une ère de transition. Elles remplissent auprès des affligés le même travail manuel que faisaient les gardesmalades d'autrefois auquel elles ajoutent une haute formation intellectuelle. Il n'en sera peut-être pas toujours ainsi! Tôt ou tard, ces demoiselles abandonneront une grande partie de leur travail manuel pour s'adonner presqu'uniquement au travail intellectuel.

Les programmes des écoles d'infirmières visent de plus en plus à un enseignement approfondi, dans le but de faire face aux exigences de la médecine dont les progrès se font à une all-

ure vertigineuse.

Le médecin qui, autrefois, remettait entre les mains de son interne les traitements manuels de ses malades lui confie maintenant le soin de faire des recherches scientifiques sur un sujet donné; il lui demande de résumer les opinions médicales émises en rapport avec tel problème nouveau, etc. Et le bon interne, après avoir terminé l'examen soigné de ses malades, n'a pas assez de vingt-quatre heures par jour pour fouiller dans la bibliothèque les solutions des problèmes demandés. Il doit par conséquent laisser à d'autres le soin de certaines techniques - apanage il n'y a pas si longtemps — des seuls médecins haut gradés!

Ces techniques lui ont été enseignées alors qu'il était lui-même stagiaire et maintenant il les confie aux gardes-malades. Ces dernières ne peuvent saisir l'importance de telles responsabilités à moins d'une compréhension suffisante de la pratique Elles doivent connaître médicale. l'hygiène, la bactériologie, l'anatomie et la physiologie; comprendre les réactions d'allergie, l'antagonisme de certains médicaments, leur posologie, leurs effets et leurs dangers. Elles doivent être au courant des tests de laboratoire les plus compliqués ainsi

que de la manipulation de nombreux instruments de physique.

Et que d'autres choses n'ont-elles

pas à savoir?

Dans de telles circonstances on comprend facilement que les dirigeantes des écoles d'infirmières aient exigé déjà un minimum d'instruction comme base à l'admission de leurs élèves et qu'elles aient grossi leurs programmes d'études.

Certaines universités ont reconnu les efforts de ces écoles et décernent un diplôme universitaire aux jeunes filles qui ont réussi les examens

qu'elles leur imposent.

En conclusion, les études sont immenses. Et il arrive un moment où les soins immédiats des malades doivent être divisés. C'est alors qu'entre en jeu l'organisation du travail en deux équipes: une pour le travail intellectuel et l'autre pour le travail manuel. Pour effectuer ce dernier on s'adresse à des aides-gardes-malades. Elles s'occupent de toute la partie non scientifique des traitements aux malades et cela sous la direction de l'infirmière; celle-ci administre les traitements médicaux prescrits par le médecin, s'occupe des tests qui lui sont confiés, étudie les techniques nouvelles, etc.

Réalisant l'étendue infinie de la science elle peut se spécialiser dans une des branches de la médecine. Là encore elle trouvera moyen d'employer toute son intelligence et son temps sans crainte de dépasser le fond de la science qu'elle aura choisie.

Nous voyons donc là l'infirmière à l'étude. Ipso facto, elle prend place dans la société au rang des savantes et par conséquent elle s'éloigne peu à peu des travaux manuels qui constituaient autrefois toute sa besogne. Pour être digne d'une situation sociale aussi élevée l'infirmière devra posséder une culture générale adéquate. Noblesse oblige! C'est là mon second point.

CULTURE GENERALE NECESSAIRE A

Il est difficile de définir exactement la culture générale. C'est en soi un terme bien vague.

Acceptons que les cours classique ou scientifique tels qu'enseignés dans nos collèges donnent à ceux qui les terminent avec succès quelques connaissances générales ou, en d'autres mots, un peu de culture générale. Ces enseignements ouvrent des horizons sur les différentes sciences et sur les N'allons pas croire que les diplômés de ces cours soient des savants le jour où ils reçoivent leur diplôme! Ce sont des individus à qui on a enseigné des connaissances générales en vue de les préparer à l'étude d'une science ou d'un art en particulier.

A un degré un peu moins élevé on peut dire que les jeunes filles possédant un diplôme de onzième année d'études sont également assez bien préparées à poursuivre des études plus approfondies. Elles savent un peu de tout et pas beaucoup de tout. Heureusement elles sont jeunes et susceptibles par conséquent d'apprendre davantage. Ambitieuses et d'un grand coeur elles entreprennent la carrière d'infirmière. Pendant trois ans leurs loisirs sont au minimum et, en dehors des sciences nouvelles qu'on leur inculque, elles ne pourront guère se cultiver.

Mais, me direz-vous, toutes ces sciences nouvelles qu'on leur enseigne font partie de la culture générale. C'est exact. L'anatomie, la bactériologie, la chimie, la physiologie, la médecine sont autant de sciences qui élargissent les horizons intellectuels. Elles donnent à l'infirmière une certaine supériorité qui lui permet de s'imposer auprès de ses patients. Et ceux-ci sont souvent étonnés qu'une si jeune fille puisse saisir le sens des nombreux mots baroques prononcés par le médecin.

Cependant, méfions-nous! Le public un peu cultivé a cherché depuis plusieurs années à comprendre un peu les problèmes médicaux et il s'est instruit dans les périodiques les plus variés. Il n'existe presque plus de journaux et de revues qui ne traitent des sujets médicaux les plus récents. Les journalistes avides de nouvelles sensationnelles scrutent les laboratoires, les hôpitaux et les universités pour y dé-

couvrir les derniers-nés parmi les sujets scientifiques. Ils lancent parfois dans le public des nouvelles médicales avant même qu'elles n'aient paru officiellement dans les journaux médicaux.

Le cinéma répand la connaissance de certains progrès de la médecine et reproduit par l'image des techniques parfois complexes; des livres de vulgarisation médicale sont également édités et mis à la portée de tous. Aussi, de plus en plus, rencontre-t-on des individus parfaitement au courant des termes médicaux et des dernières acquisitions de la médicine. doute qu'une infirmière intelligente suive ces progrès et que ses idées soient solidement établies par les articles spécialement rédigés pour elle par des organismes appropriés, revues de la garde-malade, etc.

En écoutant parler ses patients de problèmes médicaux, l'infirmière réalise que ces personnes possèdent des connaissances qui dépassent le domaine de leurs activités habituelles. L'industriel, l'ingénieur civil, l'avocat ou le chimiste, qui parlent de médecine causent donc d'une science qui n'entre pas dans le cadre de leur profession. S'ils peuvent s'entretenir de beaucoup d'autres sujets, ils démontrent par le fait même qu'ils jouissent d'une cul-

ture générale étendue.

Cette culture générale, l'infirmière doit y viser et pour plusieurs raisons. La première est sans contredit sa satisfaction personnelle. Plus une personne est instruite plus elle est en mesure d'apprécier. Connaissez-vous les plantes et les fleurs, chacune d'entre elles devient un objet d'intérêt. C'est un plaisir pour vous de les regarder; vous saisissez leurs points faibles et leurs qualités; les livres qui les décrivent excitent votre curiosité et les botanistes qui vous en causent vous passionnent.

Vous aimez les arts! Voilà qui vous permet de passer des heures inoubliables. La musique atténue les moments tristes de l'existence, la peinture et la sculpture occupent l'esprit et leur horizon est sans limite. Les artistes en vous en parlant vous enthousiasmeront, et s'il vous est donné

de rencontrer quelques génies, vous sentirez qu'ils possèdent une flamme capable de vous faire trouver la vie belle.

Tous les arts, toutes les professions et tous les métiers vous intéresseront de même, si vous vous donnez la peine

de les connaître un peu.

Le fromager qui ajoute de la pénicilline à son fromage, le mécanicien qui répare un avion quadri-moteur, le luthier qui passe ses jours à faire un violon, l'ébéniste qui exécute des meubles de luxe, etc., sont autant d'êtres humains intéressants à écouter, en autant, toutefois, que vous aurez reçu une culture générale qui vous permette de les apprécier.

Si ces personnes peuvent captiver votre esprit par leurs sciences, cela signifie que vous êtes préparées à les comprendre; en d'autres termes que votre culture générale est bonne et qu'elle vous permet d'apprécier la vie.

C'est donc pour sa satisfaction personnelle d'abord qu'il vaut la peine d'augmenter ses connaissances géné-

rales.

En second lieu, l'infirmière se doit d'avoir une bonne culture générale parce qu'elle lui permet d'avoir plus d'influence sur son entourage, et, par conséquent, peut être plus utile à la société. Le rôle d'infirmière étant un rôle exceptionnellement social par lui-même l'infirmière doit chercher à lui donner son maximum d'efficacité.

En troisième lieu, la culture générale est particulièrement nécessaire au rôle d'avenir de l'infirmière. Ce rôle d'avenir m'apparaît être celui de postes de commande. Il existe maintenant un baccalauréat en sciences hospitalières. Pour l'obtenir il faut deux années supplémentaires d'études aux trois années régulières du cours. Il existe également des cours spécialisés en hygiène, et l'avenir se charge de développer rapidement le nombre de spécialités pour infirmières.

Ces personnes spécialisées occuperont pour la plupart des rôles de premier plan, dans les hôpitaux, les universités, les services d'hygiène, etc. Sans aucun doute, avec une culture générale considérable leur influence sera des plus marquantes. Pour être pratique, disons enfin qu'elles pourront exiger des autorités qui les emploieront de forts salaires tout en se faisant respecter. Ne voyons-nous pas aujourd'hui des diététitiennes en charge des cuisines des hôpitaux commander de très larges honoraires? Il faut également à l'infirmière de l'avenir des situations qui lui procurent une vie intéressante, qui la fassent considérer par sa haute valeur et qui lui rapportent de vastes moyens de substance.

Vous dirigerez des mouvements médico-sociaux importants, vous serez à la tête d'organisations hospitalières. Les industries et les laboratoires vous rechercheront. Autant de postes importants qui exigeront en plus de vos études, des connaissances étendues. Hâtez-vous donc! Si j'avais un conseil à donner je vous dirais que, par importance, vous devez d'abord vous renseigner sur l'anglais. langue anglaise est nécessaire chez nous plus peut-être qu'ailleurs. Elle permet de se tenir au courant des activités de deux grands peuples, les Américains et les Anglais.

Une fois bilingue parfaite pensez aux arts, renseignez-vous sur la littérature, la peinture et la sculpture. Une bibliothécaire avisée vous con-

seillera judicieusement.

Si vous le pouvez, voyagez et récapitulez au plus tôt votre géographie. Elle vous entraînera dans l'histoire des peuples et dans leurs moeurs; de plus, elle élargira votre mentalité peutêtre même jusqu'à vous faire comprendre qu'un humain qui ne pense pas comme vous peut avoir raison. C'est là un point que peu d'individus peuvent réaliser et c'est là l'origine de très nombreuses incompréhensions dans le monde, de querelles et possiblement de guerres.

Il est sûrement remarquable de constater qu'une telle largesse d'esprit se rencontre fréquemment chez la personne qui a beaucoup voyagé.

Lorsque vous aurez acquis de fortes connaissances dans tous les domaines, énumérés plus haut, sans aucun doute votre esprit ne sera pas encore rassasié. Il cherchera à s'ouvrir des horizons dans tous les domaines scientifiques. De plus en plus vous aurez élevé le niveau de votre profession. Vous aurez abandonné un travail très noble, le travail manuel, mais vous continuerez à le diriger intellectuellement. Ainsi vous augmenterez la valeur de vos services à l'humanité qui vous est chère puisque vous êtes infirmières.

Que la culture générale soit donc le motto de l'infirmière de l'avenir.

Red Cross Scholarships in Manitoba

The Manitoba Division of the Canadian Red Cross Society offers a scholarship of \$600 to be given to nurses registered in the province who wish to take post-graduate courses in public health nursing at the University of Manitoba.

Essential Qualifications

1. The candidate must produce a letter from the director of the School of Nursing Education that she has met the requirements of the University for admission to the course in public health nursing.

2. She must give proof of personal aptitude for community service.

3. She must have at least a Grade XI

standing with an average of 60 per cent.

4. She must be willing to sign a contract to serve under salary in the public health field in a rural community for a period of two years immediately following her graduation from the University.

The Manitoba Division of the Red Cross has asked the Bursary Award Committee of the Manitoba Association of Registered Nurses to recommend the candidate who will receive the scholarship.

For further information apply to Commissioner R. N. Snyder, Manitoba Division, Canadian Red Cross Society, 31 Kennedy St., Winnipeg.

Interesting People

Elizabeth Lawrie Smellie, C.B.E., R.R.C., LL.D., who since 1924 has guided the destinies of the Victorian Order of Nurses in Canada as chief superintendent, has retired. Chosen the Dominion's most outstanding woman in 1942, Miss Smellie's career as a nurse and great humanitarian has won for her unlimited respect and admiration on the part of all who have known her or felt the influence of her work.

Born in Port Arthur, Ont., the daughter of a physician of Scottish descent Miss Smellie graduated from the Johns Hopkins Hospital in 1909. In 1915 she enlisted with the Canadian Army Medical Corps as a nursing sister. She served in France with No. 2 Canadian General Hospital for a year and a half rising to the rank of acting matron. She was mentioned in despatches in 1916 and received the Royal Red Cross First Class in 1917. She returned to Canada in 1918 on the staff of the Director General of Medical Service at Militia Headquarters and received her discharge from the C.A.M.C. in 1920.

Miss Smellie received her training in public health nursing at a university in Boston, and in 1922 was made supervisor of the Montreal Branch of the Victorian Order of Nurses becoming chief superintendent two years later.

In 1934 she was appointed Commander of the British Empire. Other honors conferred upon her include the Mary Agnes Snively Memorial medal presented by the Canadian Nurses' Association in 1938; the



Notman, Montreal

ELIZABETH L. SMELLIE

honorary LL.D. from the University of Western Ontario in 1942.

In 1940 Miss Smellie was appointed matron-in-chief, R.C.A.M.C., with the rank of major. In 1941 she supervised the organization of the Canadian Women's Army Corps. In 1942 her military rank was raised to Lieutenant-Colonel and two years later she was promoted to full colonel, thus becoming the first woman in the Canadian Army to hold that rank. She retired from the R.C.A.M.C. and returned to her duties with the Victorian Order of Nurses in 1944. In 1946 she was made a life member of the Canadian Public Health Association, an honor which had only been conferred on one other woman and the first time such an honor had come to a nurse.

At the recent annual meeting of the Victorian Order of Nurses for Canada, held in Ottawa, honor was paid to this gracious lady by all from the highest to the lowest in rank. The platinum pin set with diamonds and fashioned in the crest of the Victorian Order of Nurses was the most outstanding of the many beautiful farewell gifts that were presented.

From all parts of Canada cordial good wishes go to Miss Smellie that she may find rich happiness in the days that lie before her.

Culminating many long years of service with the Victorian Order of Nurses for Canada, Maude Helen Hall, has been named chief superintendent of the Order.

Born in Guelph, Ont., Miss Hall graduated in 1913 from the school of nursing of Johns Hopkins Hospital and received her public health training from the school of nursing of University of Toronto. When the United States entered World War I in 1917 she joined Base Hospital No. 18, Johns Hopkins Unit, and served in France for two years. Upon demobilization she engaged in private duty nursing until 1922 when she became a member of the nursing staff of the Massachusetts-Halifax Health Commission. next two years provided her with experience as a staff nurse in the Toronto Department of Health followed by her appointment as supervisor in the Instructive Visiting Society in Washington and later as Director of the Visiting Nurse Association of Holyoke,



MAUDE H. HALL



Gar. ta. Montreal
ALICE GIRARD

Mass. In 1928, she joined the staff of the Public Health Clinic of Dalhousie University, leaving that position in 1930 to become assistant superintendent of the Victorian Order of Nurses for Canada.

As assistant superintendent of this national nursing organization with one hundred branches spread across the Dominion, Miss Hall has gained an intimate knowledge of the varied aspects of her work. Occasional visits to the branches enabled the various staffs to become personally acquainted with her and her ever-ready assistance through correspondence has endeared her to all members of this large body of nurses whom she now will lead. Opportunity has been similarly afforded for her contacts with the Board members who join with the professional group in offering their sincere congratulations.

Always keenly interested in nursing, Miss Hall is a life member of her own alumnae association. She has taken an active part in the deliberations of the Canadian Public Health Association, Canadian Nurses' Association, and Registered Nurses Association of Ontario. When the day's work is done her chief pleasure and relaxation lies in reading a good book, listening to music or attending the theatre. She is keenly interested in art, is an ardent enthusiast for the out-of-doors and takes long tramps to discover new country-side and re-discover old haunts.

Alice Girard, M.A., has been appointed to the Head Office of the Metropolitan Life Insurance Company as Territorial Nursing Supervisor for Canada.

Born in Waterbury, Conn., of French-Canadian parentage, Miss Girard graduated in 1931 from St. Vincent de Paul Hospital, Sherbrooke, P.Q. She holds her certificate in public health nursing from the University of Toronto, her Bachelor of Science degree from the Catholic University of America, Washington, and her Master of Arts from Columbia University, New York.

For five years Miss Girard worked as a doctor's assistant in a private clinic. Her duties included assistance in home deliveries, and first aid for five industrial plants situated in a small town, the centre of a large rural area. For almost two years she served as a staff nurse with the Metropolitan Life Insurance Company. Now after five years as director of the School of Public Health Nursing of the University of Montreal and carrying the administrative responsibilities for the school as well as teaching some courses, Miss Girard is launching out into a larger sphere. For an interim period, she will combine her work as director of the School with her new responsibilities. Being completely bilingual, Miss Girard has superb qualifications for the new work she has entered. We offer our sincere congratulations.



NETTIE D. FIDLER

The Canadian Nurses' Association announces with pleasure the appointment of Nettle Douglas Fidler, B.A., as Director of the new Demonstration School which is being sponsored by the Canadian Nurses' Association and the Canadian Red Cross Society.

Born in Montreal, Miss Fidler graduated in 1919 from the school of nursing of the Toronto General Hospital. After a few months of private duty she became a head nurse in her home school. In 1923 she joined the staff



LT.-CMDR. E. W. LEDINGHAM

of the out-post hospitals operated by the Ontario Red Cross Society. Eighteen months later she returned to T.G.H. as head nurse and night supervisor. Realizing the need for further preparation Miss Fidler enrolled in the course in teaching and supervision at the School for Graduate Nurses, McGill University. For the next three years she was an instructor in the Toronto General Hospital, then became a director of nursing at the Toronto Psychiatric Hospital. In undertaking this new work Miss Fidler leaves the faculty of the school of nursing of the University of Toronto where she has been an assistant professor of nursing for several years.

Miss Fidler has always maintained a very active interest in the work of the various nursing associations. She has been both treasurer and president of the alumnae association of the school for nurses of the Toronto General Hospital. For many years she convened a committee on psychiatry for the Canadian Nurses' Association. At present she is president of the Registered Nurses Association of Ontario. Miss Fidler is a firm believer in the value of the true education of student nurses and has long advocated the necessity for careful assessment of all of the factors bearing upon this education. It is, therefore, fitting that she should be entrusted with the organization and direction of this interesting experiment which will endeavor to determine these factors. We shall watch her progress with very great interest.

Eula Winifred Ledingham, R.R.C., was appointed director of the nursing branch of the Royal Canadian Navy and nursing-officer-in-charge, R.C.N. Hospital, H.M.C.S. Stadacona, Halifax. Miss Ledingham's peacetime rank is Lieutenant-Commander.

Born in Vancouver, B.C. Miss Ledingham graduated from the Vancouver General Hospital in 1927. After two years on the staff of her home school she engaged in private duty in various places on the Pacific coast including Honolulu. In 1937 she joined the staff of the California Lutheran Hospital in Los Angeles and enrolled in courses of administration, teaching and supervision at the University of Southern California. In 1942 she returned to the Vancouver General Hospital as assistant night supervisor, resigning from that post to enlist with the naval service in 1943. Her experience and administrative ability quickly advanced her to the post of matron. She has served as matron of



Horsdal, Ottawa

ETHEL GORDON

R.C.N. hospitals on both coasts. In the King's New Year's Honor List for 1946 she was awarded the Royal Red Cross, First Class.

Her enthusiasm for outdoor activities is directed toward golf, bowling, swimming, sailing. We share in the pride of the nurses of Canada in Lieutenant-Commander Ledingham's appointment.

Ethel May Gordon has been appointed assistant supervisor of nurses, Civil Service Health Division, Department of National Health and Welfare, Ottawa.

Born and educated in Manitou, Man., Miss Gordon taught for three years in rural Manitoba before entering Winnipeg General Hospital to commence training. Following her graduation in 1927 she joined the staff of the training school office of her home hospital. Later she spent a five-year period as technician nurse in the Manitoba Medical College and two years in the Central Tuberculosis Clinic, Winnipeg. In 1936 she received her social science diploma from the University of Toronto, following this with her public health nursing diploma in 1937. She joined the staff of the Toronto Branch of the Victorian Order of Nurses in that year taking charge of the Woodstock (Ont.) Branch in 1939. In 1942 she became public health nurse under the Board of Education, Belleville. Ont., rejoining the V.O.N. as charge nurse there in 1943. In 1945 she became assistant superintendent of the Ottawa Branch.

Miss Gordon is a member of the Business and Professional Women's Club and for re-



CATHERINE FRITH

laxation enjoys camping and exploring the beauty of the Province of Ontario.

Catherine Frith has assumed her duties as superintendent of nurses at Oxbow (Sask.) Union Hospital. Mrs. Frith, who graduated from the Winnipeg General Hospital in 1923, nursed at the Fort Sanatorium for six months prior to her marriage. Returning to nursing in 1939 she was on the staff of the Fort Sanatorium for two years before becoming a supervisor at the Winnipeg General Hospital, where she served for five years.

As her favorite pastimes, Mrs. Frith lists reading and cooking and hopes she may have opportunity for both of these in her new sphere.

Commemorating the twenty-fifth anniversary of her service with the Metropolitan



EMMA ROCQUE



MARTHA RACEY

Life Insurance Company, Emma Rocque, Supervisor in the Province of Quebec, was recently feted by more than sixty of her associates. On this occasion she was presented with the medal and diamond-studded bar symbolic of her long service. In her response to the many words of praise, Miss Rocque wished that the jewel would shed a gleam "not so much a remembrance of my past activities, but a bright light for the future."

A graduate of the Hôpital St. Vincent de Paul, Sherbrooke in 1916, Miss Rocque has taken post-graduate work at l'Ecole d'Hygiène Sociale Appliquée, Université de Montréal. Prior to her appointment with the M.L.I.C. Miss Rocque worked for one year with the Victorian Order of Nurses in Montreal, then was in the social service division of the Royal Edward Institute in Montreal, for three years, followed by a brief period of industrial nursing at St. Jerome. Her many hobbies and wide range of outside interests and activities keep her in close touch with developments in her own field and with public health nursing in general. This well-deserved tribute has given great pleasure to her many friends.

Martha Rose Racey, who was gold medallist when she graduated in 1928 from McKellar General Hospital, Fort William, has been appointed science instructor in the school of nursing of the Stratford General Hospital. Miss Racey holds her certificate in teaching and supervision from the School for Graduate Nurses, McGill University. She was instructor of nurses for two years at McKellar, nurse in charge of a private hospital at Foleyet, and for the past five years was instructor at the Plummer Memorial Public Hospital in Sault Ste. Marie. Miss Racey is keenly interested in books and during the summers gets great enjoyment out of camping.

In Memoriam

Elizabeth Argue died recently in Toronto at the age of eighty-two years.

Patricia Bresnan, who graduated from St. Boniface (Man.) School of Nursing in 1911, died there in October, 1946.

Estella M. Clarkson died recently in Woodstock, Ont.

Belle (O'Reilly) Crane, a graduate of St. Boniface Hospital, Manitoba, died in Oakland, Calif.

Lydia Cressman, a native of Elmira, Ont., who received her professional training in Philadelphia and served overseas with the U.S. Army Nurse Corps, was accidentally killed recently.

Alice Cecil K. Dawkins, who was born

in New Zealand and received her training at the Liverpool Royal Infirmary. England, died recently in Montreal. On her arrival in Canada Miss Dawkins joined the staff of the Victorian Order of Nurses. In 1914 she enrolled as district nurse with the Montreal Maternity Hospital. In 1926, when the Royal Victoria Hospital and the Montreal Maternity Hospital were amalgamated, Miss Dawkins was named supervisor of the outpatient department. On her retirement in 1943 a ceremony was held at which her devotion to duty and unswerving loyalty were cited.

Edythe (Cates) Dunlop, who graduated from the Public General Hospital, Chatham,

Ont., in 1939, died suddenly on March 21, 1947. Prior to her marriage, Mrs. Dunlop had engaged in private duty.

Nellie Josephine Enright, R.R.C., a graduate of the Royal Victoria Hospital, Montreal, and of the Roosevelt Hospital in New York City, died on April 23, 1947, in Montreal.

During World War I Miss Enright spent three years in France with the McGill Unit and received her decoration for the services she rendered there. At the outbreak of World War II she again enlisted with the R.C.A.F. Nursing Service seeing service in St. Thomas and Newfoundland.

Doris E. Hyde, who graduated in 1943 from the Niagara Falls Training School for Nurses, passed away on March 27, 1947, following a lengthy illness at the age of twenty-seven years. Miss Hyde served for one year with the Victorian Order of Nurses and was engaged in floor duty at her home hospital when she was taken ill.

Margaret (Telfer) MacDuff, who graduated from the Toronto General Hospital in 1910, died recently in Toronto. Mrs. MacDuff had been engaged in private duty nursing until she became ill.

In the death of **Kate Mathieson** on April 3, 1947, at the Queen Elizabeth Hospital, Toronto, Canada loses an outstanding and familiar member of the nursing profession.

Those who have had the privilege of knowing her intimately feel that they have lost an understanding friend and a wise counsellor. She will always be remembered with affection as a woman of noble character, unassuming and kindly; a friendly personality possessing a keen sense of humor, loved and respected by a host of friends and associates.

Miss Mathieson was born in the Hebrides, Scotland. She came to Canada as a little girl settling with her parents in Tiverton, Bruce County, Ont. In 1896 she entered the Training School for Nurses of the Riverdale Isolation Hospital, Toronto. Following graduation she was appointed as head nurse there and, in 1900, was appointed superintendent of nurses, which position she held until her retirement, because of ill health, in 1943. She had the distinction of having the longest continuous record in the same hospital of any superintendent of nurses in Canada.

Miss Mathieson's services won recognition



Garcia, M. ntreal

ALICE CECIL DAWKINS

in 1935 when she was the recipient of the King George V Silver Jubilee Medal.

During the forty-three years of leadership and untiring devotion to the duties and responsibilities of her chosen profession, Miss Mathieson gave generously of her ability and time to all phases of nursing. She was a charter member of the Canadian Nurses' Association serving as councillor; vice-president of the Graduate Nurses' Association of Ontario in 1920; an active member of the



KATE MATHIESON



GEORGIE L. ROWAN

committee which was instrumental in securing legislation for registration of nurses in Ontario; an ardent member of the Riverdale Isolation Hospital Alumnae Association.

As a token of their love and esteem, the graduates of the Riverdale Isolation Hospital paid lasting tribute to Miss Mathieson on July 6, 1927, in the presentation and unveiling of a beautiful portrait of herself, painted by the late Mr. J. W. L. Forster, which has the position of honor in the reception room of the nurses' residence.

Miss Mathieson lived a full life, devoted to her profession, her family and her friends. She was interested in literature, pictures, china, handicrafts, and gardening.

Adah Moralee, oldest graduate nurse of Victoria Hospital, London, Ont., died recently after a short illness. Miss Moralee had served for twenty years as a member of the staff of the Queen Alexandra Sanatorium in London. Previously she had worked in hospitals at Coronna and Nelson, B.C.

Georgie L. Rowan, former superintendent of Grace Hospital, Toronto, and of the Private Patients' Pavilion of the Toronto Western Hospital, died recently at the age of sixty-five at her home in Mimico, Ont., after a prolonged illness. Miss Rowan graduated in 1905 from Grace Hospital with postgraduate study at Sloane and Bellevue Hospitals in New York.

Miss Rowan was a noted educationalist, lecturing in hospital administration at the University of Toronto School of Nursing. She gave early recognition to the possibilities of public health nursing and to the place of the hospital in the public health movement. An oil painting of this notable woman will hang in Toronto Western Hospital.

Miss Rowan was a worthy follower of the great and noble Florence Nightingale. Her dignity and grace, kindliness and thoughtfulness will be missed by her legion of friends. She always had time to help someone in need.

Georgie (Collins) Schofield, a graduate of the Saint John General Hospital School for Nurses in 1909, died recently in Saint John, N.B., after a long illness. Following graduation she did private duty nursing for a short time in Saint John and was a supervisor at the Saint John General Hospital until her marriage in 1916. During the war years she was very active in Red Cross work.

Mrs. William (Pickering) Slykhuis, a graduate of Regina Grey Nuns' Hospital, died recently in her thirty-eighth year.

Elizabeth (Allen) Wallace, a graduate of the Toronto General Hospital, died recently at Oakville, Ont. For some time following graduation Mrs. Wallace served on the staff of the welfare department of The T. Eaton Co. Ltd. During the recent war she was active in Red Cross and war service work.

Edythe Louise Wilson died recently in London, Ont. Miss Wilson had served as nurse in a doctor's office for forty years.

The Official Directory

Every three months, in March, June, September, and December, the full listing of the officers and committee chairmen of the provincial associations, their districts and chapters, the alumnae associations, etc., is published. Every effort is made to have these listings correct as to personnel and the spelling of names. Cor-

rections must be received by the first of the month preceding the month of publication to be included. Will you please check your listing in this issue to see that there is no error? There is no charge to you for any corrections. Please keep us informed always of any changes.

Notes from National Office

Committee on Institutional Nursing

The sub-committee on publications has completed a plan for the series of articles on "Personnel Policies." Topics have been assigned to the provincial hospital and school of nursing sections.

The secretary obtained lists from the provincial Instructors' Committees of appropriate texts for the War Memorial Library. A list of six textbooks for each subject of the nursing curriculum was drawn up and forwarded to the chairman.

An attempt is being made by the committee to establish a common nomenclature of nursing positions in the institutional field. A proposed list of titles with definitions has been forwarded to the provincial executive secretaries, with the hope that these will be forwarded to the head of the nursing departments of each hospital for constructive criticism and suggestions, and returned for further action.

As a preliminary step in devising techniques for job analysis of hospital positions, our committee made arrangements for a nurse to spend several days in the Job Evaluation office of the Hudson Bay House. Winnipeg. The nurse observed the work of two analysts who were most co-operative in discussing the various techniques, questionnaires, and other forms which have been developed for use in the job evaluation procedure conducted by Hudson Bay Company. It was felt that the forms could be readily adapted for use in evaluating jobs done by nurses and other workers in hospitals. The committee is endeavoring to modify the material received for hospital use.

Committee on Private Duty Nursing

Points discussed at meeting were as follows:

1. The need for better relationship with hospitals and public health organizations as the private duty nurse carries out a public health program in her daily routine.

2. The need for an orientation program for the private duty nurse who goes into the hospital for general staff duty. This would create a better understanding and in many cases the nurse would remain on the staff permanently.

3. The publication of a periodic bulletin from section conveners and registries to enable closer contact with private duty nurses.

4. Consideration of the national chairman contacting each provincial private duty nursing convener and nurses at provincial annual meetings for the purpose of creating more interest and discussing problems.

There is still a great shortage of private duty nurses with many unfilled calls but on the whole the situation appears to be better. There seems to be a general unrest among private duty and general staff nurses, the trend being to post-graduate courses. All provinces report an increase in daily ratio and in placement service fees.

Ontario is still studying an economic security plan with personnel practices and salary basis for private duty nurses.

A conference for registrars of private duty nursing registries throughout Ontario will be conducted in Hamilton, Ontario, June 9-10-11. This conference is conducted yearly as an educational program in registry work, counselling, interviewing, etc.

Committee on Public Health Nursing

With the availability of the report, "Salaries and Qualifications of Public Health Personnel," published recently by the C.P.H.A., the provincial sections have been asked to under-

JUNE, 1947

take a study of this report in relation to salary scales for public health nursing personnel. Upon completion they shall submit to this committee a summary of conclusions. formation will then be analyzed with a view to possible referral as contributory material from the Canadian Nurses' Association for use of the Canadian Public Health Association study committee in their later considerations.

As the Canadian Public Health Association has a committee studying "What is Essential Public Health Nursing," and as the contents appeared to show general similarity to the job analysis study, it has been decided that it would be inexpedient to proceed further in an independent study at this time.

From the provincial section reports we learn that there has been much constructive activity in the form of refresher courses, institutes and informative lectures.

Wanted-Canadian Pen-Friend

A British student nurse in her second year at Swansea General Hospital, South Wales, writes that she would like to correspond with a nurse-in-training at a general hospital in Canada. Any student nurse interested in writing to this nurse may obtain her name and address by writing to National Office.

Food Parcels for Nurses

Miss Frances Goodall, General Secretary, Royal College of Nursing, writes as follows:

We are simply overwhelmed with your great kindness in sending so many food parcels to our nurses and, as you request in your letter of the 17th February, I enclose herewith a further list of names and addresses of nurses and also of hospitals who would be glad to receive these delightful gifts.

As you know, we are going through rather a dark passage at the moment and these parcels are more than ever appreciated—they really come as a ray of sunshine in a gloomy world. At the same time we do not wish to presume too much on your generosity and

are wondering whether you, too, are beginning to feel the pinch. According to our newspapers there is a great shortage of food everywhere. However, I am sure I can leave it to your judgment as to how many parcels you send and how often.

Will you please convey to all those who so generously contribute to the despatch of these parcels our very grateful thanks and deep appreciation of all their kindness.

Provincial Association Activities

The outstanding activities of the provincial nurses' associations, as presented to the executive meeting, Canadian Nurses' Association, April 28, 29 and 30, 1947, are summarized for the information of nurses of Canada:

ALBERTA ASSOCIATION OF REGISTERED Nurses: A tentative new Act and By-laws for Alberta have been drafted for discussion and revision at the 1947 annual meeting.

The educational policy committee has worked on the following: (1) Clinical experience for student nurses to include psychiatric and tuberculosis nursing as well as experience in small hospitals. (2) Examination techniques. (3) Central Schools. (4) Regulations governing schools of nursing in Alberta, including the minimum curriculum.

The Legislative Assembly is amending educational requirements for admission to schools of nursing in Alberta.

The Alberta Nurse Placement Service will be operated in conjunction with the provincial branch of National Employment Service, Edmonton.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA: A very successful institute for head nurses was held in Victoria in January. Sixty-seven nurses attended, representing almost every branch of nursing. The institute was conducted by Mrs. Mary Tschudin of the University of Washington, Seattle.

A study of student resignations for the past five years revealed a 25.5 per cent average or that less than 75 per cent of the students who entered schools of nursing remained to complete the course.

As a result of meetings of the Joint Planning Committee on Nursing held since the last C.N.A. Executive Committee meeting:

- 1. A guide for on-the-job training of ward secretaries, ward aides, and nurse aides was prepared and distributed to all hospitals and institutions in the province.
- 2. A draft act for the training, licensing, and control of practical nurses was prepared. This draft act is similar to the Manitoba act.
- 3. A plan for a centralized school of nursing has been submitted to the provincial government. The major features of the plan are: (a) A pre-nursing course of approximately 30 weeks (one academic year). (b) A teaching centre where the pre-nursing course would be given and which would direct and control the clinical experience of students. (c) Clinical experience of approximately 108 weeks, including a 12-week orientation period. (d) Utilization of clinical fields not now used for nursing education; such clinical fields to include general and special hospitals and public health and visiting nurse organizations. (e) A proportion of the costs of the school to be borne by the students, who would be expected to pay tuition fees.

Labor Relations Committee: This committee has been very active during the winter months. Its major task was the preparation of a series of five bulletins on Employer-Employee Relationships.

The subjects of the bulletins are: Bulletin 1. The Select Committee on Labor Relations. Bulletin 2. How the Select Committee on Labor Relations Can Help You. Bulletin 3. Nursing Staff Organizations. Bulletin 4. Suggestions for Nursing Staff Meetings. Bulletin 5. Written Terms of Employment.

A report on Unemployment Insurance is in preparation and will be distributed to districts and chapters, as a follow-up on the C.N.A. brief distributed last fall.

Select Committee on Labor Relations: Numerous requests have been received for advice and for interpretation of the R.N.A.B.C. personnel practices and their application to specific situations. These requests have come from nurse employees, nurse administrators, and lay administrators. Joint conferences with three employing bodies have been held, attended by members of the nursing staff concerned and the Select Committee.

The Provincial Department of Labor has certified bargaining representatives elected by the nursing staffs of seven hospitals and one visiting nurse organization, as follows: Nanaimo General Hospital; North Vancouver

General Hospital; Royal Columbian Hospital, New Westminster; Royal Jubilee Hospital, Victoria; St. Joseph's Hospital, Victoria; St. Mary's Hospital, New Westminster; St. Paul's Hospital, Vancouver; Victorian Order of Nurses, Vancouver.

Application for certification has been made for bargaining representatives elected by the nursing staff of one other hospital.

One group has elected members of the Select Committee only; other negotiating panels will be representative of the nursing staff involved and the Select Committee.

Decisions made at the annual meeting include:

- 1. Amendments to the Constitution and By-Laws: (a) Abolishing sections and setting up Committees on Institutional Nursing, Private Duty Nursing, and Public Health Nursing. (b) Two additional committees—on Educational Policy and on Student Nurse Activities. (c) The Committees on Labor Relations and Health Insurance are now standing committees. (d) A re-instatement fee of ten dollars. Nurses whose membership has lapsed because of non-payment of the annual fee will pay the re-instatement fee, plus the current annual fee, before being re-instated.
- 2. Revised · Personnel Practices were approved. Major changes are: (a) The recommended basic minimum salary for a registered nurse in full employment is \$140 per month. (b) The recommended work week is forty-four hours. (c) A statement of terms of employment, signed by the employing officer and the employee, is to be given to each nurse now permanently employed and to each new employee.

A sample employment contract form has been prepared for distribution.

- 3. Authorization was given for the employment of a full-time Personnel Consultant.
- 4. A fund is to be established, based on twenty-five cents from each membership fee, for the purpose of defraying the expenses of a delegate from each chapter to annual meetings.

Student Nurses' Association of British Columbia: Delegates from each of the seven schools of nursing were guests of the registered nurses' association at a dinner meeting. Following the meeting, the Student Nurses' Association was formally organized and the officers elected.

MANITOBA ASSOCIATION OF REGISTERED NURSES: The director of the Provincial Placement Service has resigned. The work is to be carried on for the present under the executive secretary.

A special committee was set up by the Minister of Health and Public Welfare to study the training of nurses and the supplying of nursing material suitable for rural hospitals. The M.A.R.N. has two representatives on this committee.

NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES: A new chapter has been organized in Campbellton.

There is a shortage of nurses in every branch of nursing in New Brunswick. The Deputy Minister of Health requested the opinion of N.B.A.R.N. of the advisability of bringing nurses from European countries, chiefly to work in the tuberculosis sanatoria. To date no definite decision has been made regarding this project.

The minimum curriculum for schools of nursing is under revision. The association is in accord in support of an effort on the part of the Children's Aid and Family Welfare Societies to have established in New Brunswick some form of special facilities to take care of the needs of subnormal people, especially children.

REGISTERED NURSES' ASSOCIATION OF NOVA SCOTIA: A survey of Economic Security for Nurses has been undertaken by the General Duty Section.

Consideration is being given to university entrance qualifications for admission of students to schools of nursing in Nova Scotia.

REGISTERED NURSES ASSOCIATION OF ONTARIO: Community nursing registries have been established in two more centres, making a total of twenty-four organized registries in Ontario.

Word has been received from the Deputy Minister of Health of Ontario regarding the admission to Canada of nurses from the Balkan States and Poland. The opinion expressed by the members of the Board of Directors was "that we accept the responsibility for admitting our share of displaced European nurses, provided they meet our recognized professional standards or are willing to take additional training in order to meet them."

A bill to amend the Nurses Registration Act to include provision with respect to the training and registration of the certified nursing assistants was introduced by the Minister of Health before the Ontario Legislature. The bill stated that the name would be changed from the "Nurses Registration Act" to "The Nurses Act 1947."

The Legislation Committee has prepared Part I of a draft Practice Act dealing with professional nurses only.

Part II deals with nursing assistants. Both parts were presented at the annual meeting in April.

REGISTERED NURSES ASSOCIATION OF PRINCE EDWARD ISLAND: Several meetings of the Legislation Committee have been held. Copies will be sent to each member of the nurses' association.

Association of Nurses of the Province of Quebec:

The Quebec Nurses Act: The licensing act came into force on January 1, 1947.

The new headquarters at Montreal are spacious, light and airy. One experiences the sort of sensation in these new and adequate surroundings as we occasionally do when visiting one of our present-day luxurious and well-organized nursing schools—the sort of feeling that you wish you were going to begin life all over again. We have a set-up now that any nursing association could well be proud of.

Examinations: Our Boards of Examiners are particularly busy people and are responsible for the conduct of examinations (a) twice yearly at two French universities, (b) twice yearly in all English-language schools for students who have completed their first year, with supplementary sessions for failures six weeks after each session; and (c) twice yearly for all English-language graduates. All the mechanics in connection with the examinations conducted by the English Board are carried out at association headquarters, the volume of work having doubled the past two years.

Danish nurses: Arrangements have been made for nine Danish nurses to secure experience in Montreal hospitals during the present year. All negotiations include the question of their eligibility to secure our licence to practise in Quebec.

British nurses relief: Generous and lovely Canadian handicrafts to furnish one double bedroom in a Rest-Breaks Home have been forwarded to Barton-on-Sea. English chintz and lining to provide window drapes for the living and dining-rooms have also been sent for the same Rest-Breaks Home.

Auxiliary nursing: A bill is being drafted by our committee which we hope will even-

tually result in an Act relating to the preparation and supervision of this group.

SASKATCHEWAN REGISTERED NURSES' ASSOCIATION: The association has been called upon to co-operate in many matters affecting nurses and nursing service. It is hoped that the grading of hospitals throughout the province will do much to raise standards of employment and service.

A schedule of minimum salaries recommended for institutional nurses was endorsed by this association. Copies were sent to superintendents in institutions throughout the province. Already quite a number of hospitals report the adoption of these salaries.

Classification of civil servants, including public health nurses, has resulted in a new and improved salary schedule being established, not only for nurses on the provincial staff but also for nurses employed on other agencies.

A uniform schedule of fees for private duty nurses throughout the province has also been agreed upon and endorsed by this association. Receipt books for use by private duty nurses are now available at the provincial office.

In a number of schools students are now

being given one long day off per week, and the institution of an eight-hour day and six-day week seems much nearer realization.

Several meetings have been held in connection with the status of student nurses and steps are being taken which it is hoped will safeguard the educational standards in schools.

Meetings with superintendents and superintendents of nurses in hospitals conducting schools of nursing have been held and it is felt that an interchange of ideas will lead to greater uniformity.

It is hoped that in the near future affiliation between general and mental hospitals will be arranged.

Announcements in the press regarding the professional acts have been declared to be premature by government authorities.

Explanation

With reference to Table III in the April, 1947, issue of the *Journal* on Page 284, please note the following: First-year certificate course in Supervision, Special Fields, and Clinical Supervision included under the letter "G".

To Meet Mounting Costs

For the past twenty-four years, the subscription rate for *The Canadian Nurse* has been two dollars per year. In that time, the *Journal* has almost trebled in size. Its increasing usefulness is reflected in the steady growth of the circulation. This expansion is exceedingly gratifying. However, part of the picture is seldom realized by the individual subscriber—the fact that the costs of publication have sky-rocketed compared to what they were in 1923.

In order to balance the steadily rising costs, the Executive Committee of the C.N.A. has decided that it is folly to continue to distribute the *Journal* at a figure that is far below the actual cost. Accordingly, on and

after October 1, 1947, a new scale of subscription rates will be in effect. The annual subscription rate becomes \$3.00 per year; a special two-year rate is offered for \$5.00. Student nurse subscription rates are to be kept as low as possible at \$2.00 per year. Foreign, including United States, subscriptions will be \$3.50 per year.

All subscribers whose subscription expires in any month during 1947, may renew at the old rate providing payment is received in the *Journal* office by September 30, 1947.

We believe that every subscriber will approve the decision thus to avoid any curtailment of the *Journal's* expansion. We ask for your continued understanding and support.

Notes du Secrétariat de l'A. I. C.

Les Activites des Associations Provinciales

Les associations provinciales présenteront un rapport de leur plus importantes activités lors de l'assemblée du comité exécutif de l'Association des Infirmières du Canada, le 28-30 avril 1947. Nous les réunissons ici pour renseigner les membres de l'association.

L'Association des I.E. de l'Alberta: Une nouvelle loi et de nouveaux règlements ont été préparés et seront présentés lors de l'assemblée annuelle pour discussion et revision. Le comité chargé de considérer la ligne à suivre en matière d'éducation a étudié les sujets suivants: (1) L'expérience clinique pour les élèves infirmières chez les malades en psychiatrie et en tuberculose et aussi dans les petits hôpitaux. (2) Examen sur la technique. (3) Une école centrale. (4) Les règlements régissant les écoles d'infirmières de l'Alberta, le programme minimum des études.

L'assemblée législative est à amender la loi déterminant le degré d'instruction nécessaire à l'admission dans une école d'infirmières de l'Alberta. Le bureau de placement pour infirmières fonctionnera conjointement avec le bureau de placement fédéral à Edmonton.

L'Association des I.E. de la Colombie-Britannique: Une très intéressante série de conférences fut donnée à Victoria en janvier. Soixante-sept infirmières de toute les catégories du nursing étaient présentes. Mme Mary Tschudin de l'Université de Washington, Seattle, fut la conférencière. Une étude, faite sur les causes des départs des étudiantes durant les cinq dernières années, révèle que moins de 75 pour cent des élèves terminent leur cours.

Voici le résultat d'une assemblée d'un comité conjoint tenue sur le nursing lors de la dernière assemblée du comité exécutif de l'A.I.C. Il a été préparé:

- 1. Un guide pour l'entraînement durant leur travail, des secrétaires employées dans les départements de l'hôpital et des aides; ce guide fut distribué dans tous les hôpitaux et institutions de la province.
- 2. Un projet de loi concernant les aides (practical nurse). Ce projet de loi est semblable à la loi du Manitoba.
- 3. Un projet d'une école centrale pour infirmières a été soumis au gouvernement. Les

points importants de ce projet sont: (a) Un cours préliminaire d'une durée approximative de 30 semaines (une année scolaire); (b) un centre d'enseignement où le cours préliminaire sera donné et d'où l'expérience clinique pour les étudiantes sera dirigée et vérifiée; (c) une expérience clinique d'environ 108 semaines, comprenant 12 semaines d'orientation professionnelle; (d) l'emploi de tout champ clinique qui n'est pas actuellement à la disposition des infirmières pour leur formation; ce champ clinique comprend les hôpitaux spécialisés, les services de santé et les organisations d'infirmières visiteuses; (e) une partie du coût de ce cours devra être à la charge des étudiantes.

Comité des Relations du Travail: Ce comité a été très actif durant l'hiver, son principal travail a été de préparer une série de cinq bulletins sur les relations entre patrons et employés.

Voici le titre de ces bulletins: (1) Le comité choisi des relations ouvrières. (2) Comment le comité choisi des relations ouvrières peut vous aider. (3) Les organisations parmi le personnel d'infirmières. (4) Quelques suggestions lors des assemblées d'infirmières. (5) Les conditions de travail données par écrit.

Un rapport sur l'assurance-chômage est en préparation et sera distribué aux associations de districts et aux chapitres, pour faire suite au résumé distribué l'automne dernier par l'A.I.C.

Le Comité Choisi des Relations Ouvrières: Ce comité a reçu plusieurs demandes, de conseils et d'interprétation sur la ligne de conduite donnée concernant le personnel d'infirmières dans certaines situations particulières. Ces demandes ont été faites par des infirmières employées, des infirmières chargées de l'administration et d'administrateurs hors de la profession.

Des conférences ont été tenues avec trois groupes d'employeurs, des membres du personnel employé (infirmières) intéressées étaient présentes et les membres du comité choisi.

Le Ministère Provincial du Travail a certifié comme agent négociateur les représentantes élues par les organisations suivantes: Nanaimo General Hospital; North Vancouver General Hospital; Royal Columbian Hospital, New Westminster; Royal Jubilee Hospital, Victoria; St. Joseph's Hospital, Victoria;

St. Mary's Hospital, New Westminster; St. Paul's Hospital, Vancouver; Victorian Order of Nurses, Vancouver.

Une autre demande a été faite pour les infirmières choisies comme représentantes par un autre hôpital.

Un groupe a élu les membres du comité choisi en relations ouvrières; un autre groupe a élu des représentantes de l'hôpital et du comité choisi.

Voici quelques décisions prises lors de l'assemblée annuelle:

- 1. Amendements à la loi et aux règlements: (a) Les sections seront abolies et remplacées par des comités sur le nursing institutionnel, le nursing en service privé et en hygiène publique. (b) Deux nouveaux comités seront formés; l'un sur l'objectif en éducation et l'autre sur les activités des étudiantes. (c) Les comités des relations du travail et des assurances-santé sont maintenant permanents. (d) Les infirmières n'ayant pas leurs noms au registre à cause de leurs arrérages peuvent être de nouveau inscrites en payant \$10 plus la contribution de l'année courante.
- 2. Une revision des conditions de travail a été faite, on recommande: (a) Un salaire minimum de \$140 pour une infirmière enregistrée ayant un emploi permanent; (b) une semaine de quarante-quatre heures; (c) que les conditions de travail soient données par écrit à chaque infirmière acceptant un emploi permanent et soit signées par l'employée et l'employeur ou son représentant; un modèle de contrat a été préparé et distribué.
- 3. L'emploi d'un expert en relations du personnel a été autorisé.
- 4. Un fond a été établi, afin de défrayer les dépenses des délégués de chaque chapitre à l'assemblée annuelle.

L'Association des Etudiantes de la Colombie-Britannique: Les déléguées des sept écoles d'infirmières furent les invitées de l'association des infirmières enregistrées lors de l'assemblée annuelle. Aprés l'assemblée annuelle, l'association des étudiantes fut organisée et les dignitaires furent élues.

L'Association des I.E. du Manitoba: Un comité spécial a été organisé par le Ministre de la Santé et du Bien-Etre pour étudier les problèmes des hôpitaux ruraux concernant les écoles d'infirmières. L'A.I.E.M. a deux représentants sur ce comité.

L'Association des I.E. du Nouveau-Brunswick: Un nouveau chapitre a été organisé à Campbellton. Il y a une pénurie d'infirmières dans toutes les catégories du nursing. Le Sous-Ministre de la Santé désire avoir l'opinion de l'A.I.E.N.B. sur le projet de faire venir des infirmières d'Europe dans le but de les employer principalement dans les sanatoria. A date, aucune décision n'a été prise.

Le programme d'étude minimum pour les écoles d'infirmières sera revisé. L'association appuie les demandes de la "Children's Aid and Family Welfare Societies" pour que des moyens soient pris afin de venir en aide aux sous-doués, particulièrement les enfants.

L'Association des I.E. de la Nouvelle-Ecosse: Une enquête sur la sécurité économique pour les infirmières a été entreprise par les infirmières en service général. L'on a parlé pour l'admission aux écoles d'infirmières d'exiger le degré d'instruction demandé par l'université.

L'Association des I.E. de l'Ontario: Deux nouveaux registres pour infirmières ont été établis, ce qui porte le nombre des registres organisés dans l'Ontario à vingt-quatre.

Un mot du Sous-Ministre de la Santé nous est parvenu concernant l'admission en pays d'infirmières des Etats Balkaniques et de Pologne. Le comité de régie a émis l'opinion suivante: Que nous acceptions nos responsabilités envers les infirmières européennes en admettant au pays un certain nombre d'entre elles, pourvu qu'elles aient le même standard professionnel que le nôtre ou qu'elles acceptent de poursuivre leur formation jusqu'à ce qu'elles aient atteint ce niveau professionnel.

Un projet de loi pour amender la loi des infirmières incluant la formation et l'enregistrement des aides, a été présenté par le Ministre de la Santé au parlement. La loi dit que le nom de "Nurses Registration Act" sera changé en "The Nurses Act 1947."

Le comité de législation a préparé la première partie concernant les infirmières professionnelles. La deuxième partie concernant les aides devait être présentée avec la partie, lors de l'assemblée annuelle.

L'Association des I.E. de l'Ec-dis-Prance Edouard: Le comité de législation a tenu plusieurs assemblées. Des copies des délibérations seront envoyées à chaque membre de l'association.

L'Association des Informères de la Province de Québec: La loi autorisant toute informière exerçant la profession à obtenir une licence est entrée en vigueur le 1er janvier 1947.

Les nouveaux quartiers de l'association sont spacieux, confortables et le travail en est facilité. Bureau des Examens: Les membres de notre bureau sont très occupées à faire passer des examens (a) deux fois l'an conjointement avec deux universités de langue française, (b) deux fois également aux élèves des écoles d'infirmières de langue anglaise qui ont complété leur première année; un autre examen supplémentaire est tenu après six semaines pour les élèves ayant droit de reprise et (c) deux fois l'an aux élèves des mêmes écoles qui ont terminé les trois années d'études. Tous les préparatifs concernant ces examens sont faits à nos bureaux, ce travail a doublé depuis deux ans.

Infirmières au Danemark: Neuf infirmières du Danemark ont demandé à faire du service dans les hôpitaux de Montréal durant l'année. Il a été nécessaire de conclure des arrangements spéciaux à ce sujet, pour la durée de leur séjour au pays.

Secours aux Infirmières Anglaises: Des cretonnes, des carpettes et couvre-lits, produits de l'artisannat québecquois, ont été envoyés à la maison de repos pour les infirmières.

Aides ou Auxiliaires: Un projet de loi a été préparé par notre comité. Nous espérons qu'il en résultera une loi concernant la préparation et la surveillance de ce groupe.

L'Association des I.E. de la Saskatchewan: On a fait appel aux bons offices de l'association dans bien des questions concernant les infirmières et le service. Nous espérons que le classement des hôpitaux de la province aidera à élever les standards du service hospitalier et des conditions de l'emploi.

Un barême de salaires minimum recommandé pour les infirmières d'hôpitaux fut appuyé par l'association. Des copies furent envoyées à toutes les directives des institutions de la province. Déjà un certain nombre d'hôpitaux ont adopté ces salaires.

Une nouvelle classification des employés civils comprenant les infirmières hygiénistes a eu comme résultat une nouvelle et meilleure échelle de salaires, non seulement chez les infirmières au service de la province, mais aussi chez les infirmières employées par d'autres agences sociales.

A la suite d'un accord, des honoraires uniformes pour les infirmières du service privé pour toute la province ont été fixés et approuvés par l'association. Les infirmières du service privé peuvent se procurer des cahiers de reçus au bureau provincial. Dans un certain nombre d'écoles, les élèves ont une journée de congé par semaine; il semble

que l'institution de la journée de huit heures et la semaine de six jours est sur le point de se réaliser.

COMITE DU NURSING (HOPITAUX)

Un sous-comité a complété les plans pour une série d'articles sur la politique a l'égard du personnel. On a fait le choix de six livres sur différents sujets en nursing dont on a fait parvenir les titres à la convocatrice du comité du souvenir.

ANALYSE DU TRAVAIL

Comme travail préliminaire notre comité voulant trouver une technique pour analyser le travail propre à chacune des positions à l'hôpital, notre comité a pris des arrangements pour qu'une infirmière passe plusieurs jours à la "Hudson Bay House," Winnipeg. L'infirmière a observé deux analystes qui ont prêté leur concours à discuter les techniques diverses employées, les questionnaires et autres formules qui ont été préparées et employées par la Cie de la Baie d'Hudson. Nous croyons que ces formules peuvent être adaptées à nos besoins et employées pour évaluer le travail fait par les infirmières et autres membres du service hospitalier.

COMITE DU SERVICE PRIVE

Les sujets suivants furent discutés lors des assemblées:

- 1. La nécessité qu'il y ait de meilleures relations entre les hôpitaux, les organisations publiques, et l'infirmière du service privé qui exécute dans son travail de tous les jours un programme de santé.
- 2. La nécessité d'un programme d'orientation pour l'infirmière du service privé qui va à l'hôpital faire du service général. L'entente serait meilleure et dans bien des cas l'infirmière deviendrait permanente.
- La publication d'un bulletin de la convocatrice du comité et des registraires afin que les infirmières du service privé aient un contact plus étroit avec la registraire.
- 4. Que la convocatrice nationale du service privé considère la possibilité de se mettre en relation avec toutes les convocatrices provinciales, et les infirmières du service privé aux assemblées annuelles, dans le but de discuter de leurs problèmes.

Il n'y a pas encore assez d'infirmières pour le service privé, bien que la situation soit améliorée.

Une conférence pour les registraires des infirmières du service privé aura lieu à Hamilton, Ont., les 9, 10, 11 juin. Cette conférence a lieu annuellement pour aider les registraires.

COMITE DE L'HYGIENE PUBLIQUE

A la suite du rapport publié récemment par la C.P.H.A. sur les salaires et la compétence du personnel en hygiène publique, une étude a été entreprise afin de comparer les données de ce rapport avec la situation actuelle. Le résumé de cette enquête sera analysé et envoyé à l'A.I.C.

Comme le "Canadian Public Health Association" a un comité chargé d'étudier, l'essen-

tiel du nursing en hygiène publique et que le travail accompli par ce comité ressemble beaucoup à l'analyse du travail il a été résolu de s'en tenir à celà pour le moment.

COLIS POUR LA GRANDE-BRETAGNE

Mlle Frances Goodall, secrétaire générale du Collège Royal des Infirmières, envoie une lettre de remerciements pour les colis de nourriture reçus. La reconnaissance déborde, les secours reçus empêchent les infirmières âgées et malades de trop ressentir les effets du rationnement.

Nursing with UNRRA in Greece

(Continued from page 446) mentioned here that the Greek graduate nurses are a well-trained, capable, and intelligent group. shortage of graduate nurses means that a great deal of the nursing service is carried by practical nurses, who may or may not have had training for their work. UNRRA nursing section co-operated closely with the Greek Government and the Greek Nursing Advisory Committee in working out a plan to provide a more adequate supply of nurses. Recruitment of student nurses to existing schools was promoted. These schools, however, although their standard of training is high, were far too few, there being only three in Greece, and these all situated in Athens. In April of 1946 a new school of nursing was opened on Mitylene Island, one of the larger islands in the Aegean Sea, and plans were being made to open two more on the mainland. A great deal still requires to be done, however, to improve conditions of work, salaries, and general welfare of the nurses in Greece. The chief of our nursing section, Miss Olive Baggallay, a very able English nurse, worked closely with the Ministry of Health and Greek Nursing Advisory Committee in drafting a Nursing Law. If passed, this will provide for a nursing section within the Ministry of Health and will improve the status and living and working conditions of all nursing personnel.

UNRRA nurses assisting in Greek hospitals found a great variation in In some institutions, conditions. standards of care were high considering the many difficulties under which the staffs worked, while in others they were low. Among the hospitals in Athens there were some which compared favorably with good Canadian hospitals. Generally the hospitals were very overcrowded. For example, I have seen patients being cared for on stretchers in corridors, two patients in one bed, and men and women occupying the same ward. Sanitary facilities, kitchens, and laundries were usually very inadequate. In many of the provinces, hospitals were being run without graduate nurses. Greek Red Cross volunteers, who gave splendid service during the years of war and occupation, in many instances continued to give their services in hospitals. All these volunteers had had an organized course of training, many of them in the Greek Red Cross Hospital in Athens, a modern, well-equipped, well-organized hospital. In the urban capital area, where there is a large percentage of the hospital and public health facilities, teaching courses for graduate nurses, in both the hospital and public health fields, were conducted by UNRRA nurses. In addition, many classes for practical nurses in hospitals and clinics were given throughout Greece. Usually a Greek graduate nurse worked with the



Outdoor school

UNRRA nurse in teaching the practical nurses and following through on

the teaching.

In the rural areas where UNRRA nurses worked they co-operated closely with local health officers and doctors and nurses in any existing health organizations. They conducted classes for practical nurses, carried on a program of village visiting with follow-up of health problems, promoted immunization campaigns, stimulated the formation of village health committees, and supervised the distribution and use of UNRRA medical supplies and drugs. Whenever possible Greek graduate public health nurses were employed by UNRRA to assist the imported UNRRA nurses. It was the hope that these Greek nurses would carry on this work after the withdrawal of UNRRA, as one of the greatest needs in Greece is the development of public health work. The Ministry of Health and agencies carrying public health work, such as the Greek War Relief and Patriotic Foundation, are all aware of the need for the development of public health and plan to extend their programs as much as possible.

At present, the small number of



Plowing in Central Greece

public health nurses who are doing district visiting have great difficulties and frustrations to face in their work. They have not the health and social facilities to turn to which we have in our country. Picture the family visited by an UNRRA nurse in the company of a Greek nurse whose district was in one of the poor suburbs of Athens. A sister and a brother, orphans of eighteen and twelve respectively, lived alone in a small one-roomed hut, very sparsely furnished and with one cot only. The sister was suffering from tuberculosis in its last stages. At night the young brother slept on the floor beside his sister, and during the day sold cigarettes on the streets of Athens to earn money for their food. Examination showed him to be suffering from adenitis. It was impossible to obtain a bed in a sanatorium for the sister as the waiting lists for tuberculosis sanatoria are hopelessly long. is just one example of the many problems faced by a public health nurse in Greece today.

In the rural areas of Greece conditions are still very primitive. UNRRA personnel in country districts had many strange experiences and had to accustom themselves to many inconveniences. Sanitary facilities are often just lacking. The roads are narrow and winding and in very bad repair, and bridges which had been blown up all over the country are only gradually being rebuilt. jeep is the best means of transport, but many villages cannot be reached by jeep, and travel by donkey on a wooden saddle becomes necessary. The donkey is the common beast of burden. He is seen all over, in cities and country, laden with heavy loads of wood, or hay, or barrels of water, Although signs of distressing poverty are still seen, especially in the villages, conditions had improved a great deal by the summer of 1946. People appeared to be better dressed and better fed. In villages which had been burned out, by the Germans, homes were being rebuilt either under the shelter program or through the efforts of the

villagers themselves. Great improvement had resulted from the extensive D.D.T. spraying program. The malaria incidence and the menace of flies and other pests were greatly reduced. Of all these results the population was most appreciative.

Very great suffering resulted from the financial inflation which prevailed. The disparity between the income of the average worker and the cost of living often seemed almost hopeless. When I first went to Greece, the drachma, the standard of Greek currency was 148 to the dollar, and when I left it was 5,000 to the dollar. To some extent high costs were due to the difficulties in transport. Truck transport is still in short supply; shipping is below its pre-war level; and railway communications are only being re-established gradually. The streetcars and motor-buses in Athens were fantastically jammed, with people hanging on outside and barefoot boys sitting on the bumpers. Many of the buses looked as if they were about to disintegrate at any moment. During the years of war and occupation the population of Athens was greatly increased with people coming in from the rural areas. In Athens itself one did not get a full appreciation of the food shortage, as the farmers brought their produce to the cities where they commanded better prices, and consequently the markets seemed to have plenty of meat and vegetables.

Greece is truly a beautiful country with its miles of sea coast, its mountains and valleys, groves of gnarled olive trees, fig and orange trees, and its fields of grape-vines. But many parts of it are stony and barren and one can see why the country is so poor. The beautiful sparkling blue of the Mediterranean sea and sky has not been exaggerated and is a perpetual delight. The villages, nestling in valleys or on mountain sides with their small white-washed,



The Parthenon

tile-roofed houses, look very picturesque. The shepherds in their picturesque garb, tending their flocks of goats and sheep, give a romantic note to the landscape.

Athens is well described in Milton's words as "the eve of Greece." All the Greeks love and are proud of their capital city, with its beautiful historical landmarks such as the Temple of Zeus, and the Acropolis with its superb Parthenon and other temples. All through Greece one may visit the ruins of ancient civilizations such as Mycenae, Delphi, Epidaurus, Old Corinth, Knossos, etc. These are most fascinating places to visit, and only after seeing them does one realize why Greece is referred to as the cradle of civilization. The Greeks are a keen-minded, intelligent people, and are naturally very proud of their ancient history. It would be hard to find a people more interested in politics. One may hear even small boys talk politics on the streets. As has been observed many times before, the Greek people seem to find it difficult in times of peace to unite their efforts and work toward the common good. putting up such an heroic struggle during the war and living so courageously through such terrible days, it is to be hoped that now they will be able to join together in a united effort to work out a better and brighter future for their country.

accination in the USSR

The 150th anniversary of Jenner's discovery of vaccination against smallpox was recently celebrated by the Soviet medical world. Vaccination is strictly enforced in the

Soviet Union since the time of Lenin's decree which made it compulsory. Vaccination is performed before the age of one year and subsequently repeated at 4, 8, and 18 years.

STUDENT NURSES PAGE

So It's Your Graduation Day

BETH LAYCRAFT

So IT'S YOUR GRADUATION DAY! Welcome, "Miss Nightingale," to our sisterhood.

Three years finished! When you started you didn't think they would ever end, did you? And they flew past so quickly you can hardly believe it. I know you might not do it again, but I know, too, that you wouldn't have missed it. Now you have the nurse's stamp. Come what may, you will always be a nurse. My mother, also a nurse, says that cupid is the only one who takes a nurse from nursing and he only borrows her. Even as a housewife she is still a nurse. Indeed, time and circumstance often bring her back into the field.

You will be lonely in this new life as a graduate nurse. For three years you have lived intimately and vitally with your classmates. worked together and you groused together of your common grievances. You studied together and you played together. You shared your thoughts and probably your clothes and maybe even your boy friends. Your interests were common, your viewpoints united. Now it will be very different. The dear intimacy of your training days is gone forever and first thing you know you will find yourself discontented, vaguely unhappy.

What to do about it? Expand, my dear "Miss Nightingale." Broaden out. What of your hobbies? What of the community clubs and activities? What of your other friends? (Almost

forgot you have any who aren't nurses, didn't you?) Don't let nursing and nurses be your whole life. Remember you aren't only a nurse but a person and a citizen living in a broad and interesting society.

Now that you have graduated and written your R.N. examinations and think your studies have ended, you will really start to learn. You may decide to specialize in the field of your choice or you may prefer general or private duty. But whatever you do, don't stop learning! Nothing is sadder than the nurse whose education stopped at her graduation. Know about the new drugs and how they are used. Know the new treatments. What are the trends in nursing education? in nursing legislation? This is an age of pro-

gress. Keep abreast of it. And I want to advise you new graduates to be weaned from your training school. Of course each of us knows that our training school is the best, (Heaven forget and forgive the things we said about it when we were there!), and we tend to think the other schools are inferior and the other ways all wrong. But remember, every school trains both good and bad nurses. It is something in you and not in your school of nursing which determines your degree of success. If you wish to work in your home hospital you will serve it better by leaving it for a time. You will be amazed how much you will learn and how your tolerance will grow

470 Vol. 43, No. 6

THE CANADIAN RED CROSS SOCIETY QUEBEC PROVINCIAL DIVISION

NURSING OUTPOSTS TERMS OF EMPLOYMENT OF NURSES

Salary:

- 1. Registered Nurses with Public Health qualifications: \$1,500 per annum with annual increment of \$100 to a maximum of \$2,000 per annum.
- 2. Registered Nurses with Hospital or Private Duty experience only, \$1,380 per annum, with annual increment of \$60 to a maximum of \$1,800.

Maintenance:

Complete maintenance is provided by the Red Cross. At each of the six Outposts now operating in the Province of Quebec there has been completed or in process of construction a Clinic Centre with residential quarters for the Nurse or Nurses.

These buildings all have central heating, running hot and cold water, drainage, refrigeration, and wired for electric lighting.

Maintenance includes domestic help, food and lodging, drugs and supplies, and all the expense of operating the centre.

Transportation in the area is provided; in some areas by automobile in summer and/or by hired vehicle with driver.

Holidays:

One month away from the duty Post, approximately every six months, viz: two months in each year. One half of the two-month period to be spent in study or experience approved by the Red Cross Society. Should such a study period be taken at a centre which is not the holiday home of the Nurse, maintenance will be paid by the Red Cross.

Transportation to and from the Duty Post:

When first going on duty and subsequently at each holiday period the Red Cross Society will pay cost of transportation as between either Montreal or Quebec and the duty Post.

For further information apply to:

The Canadian Red Cross Society Quebec Provincial Division 3416 McTavish St. Montreal 2, Quebec

JUNE, 1947

after six months in another hospital. Of course, the more it differs from your own school the more you will

benefit from its experience.

The most important thing in nursing is not the letters R.N. after your name (aren't you proud of them?), nor your sterile technique, nor the accuracy with which you remember the details of each nursing procedure. The thing that matters most is the response you get from each patient.

Don't misunderstand me. things such as techniques, ethics, procedures, etc., which filled your training days, are very important. Your application of them is essential. Let them become automatic. your care of each patient — let that be fresh and new each day. We can't put down a set of rules for accom-As the personalities plishing this. of nurses vary, so will their methods. But the basis is love, understanding, and the respect of every patient as a separate person with his own peculiar problems. Regardless of age, race, creed, or wealth you must respect each as an individual. his nurse, meet him in a crisis when the things which give him security and stability may be seriously threatened, when pain, fear, and apprehension fill his day. How will you handle him? How will you help

him? Give generously of yourself. It will play an important role in his recovery and make your name blessed in his memory. Those little extra things, beyond the line of duty, really matter. It may be only a word of praise or encouragement. them when you can. The other day an old woman told me proudly, "When Jim was born I had pains for two days and the nurse told me I was one of the pluckiest cases she ever had." These words, which might so easily have been left unspoken, have been treasured half a century.

With your graduation you have accepted a new responsibility to society - service. It may take you to the lonely outposts of civilization. It may place unexpected duties and obligations upon you for which you may not feel suited or qualified. Its routine may bore you. You may be over-worked and very lonely. reward is certainly not wealth and certainly not fame (to most of us But to the good nurse anyhow). there comes a something that is rich reward indeed. It is filling the gap when the need is desperate, seeing the life nearly gone come back under your skilled care. is being a source of strength and hope in time of trouble. It is a deep inner satisfaction and its coming will be written plainly on your face.

A Nurse's Prayer

O word of God, I dedicate for Thine Own Sake, Myself to Thee, for this great work I undertake.

Take Thou my eyes, and teach me how to see
The clearest way to nurse the sick for Thee.

My hands — guard them, and show me how to prove How kind and gentle is a nurse's love!

Take Thou my feet, give swiftness to their tread, In answering every call from the poor sufferer's bed.

Touch Thou my lips, guard Thou my tongue, Uttering only words of kindness to each one.

O Lord, I pray that, coming face to face with death, I may have faith and hope with each one's dying breath.

And, when I am a night nurse, please to guide My actions. Be near my patients and watch by my side.

O Lord, I ask Thee, hear me while I pray; Be in me, through me, with me, all the way.



Getting the air, Sis?

A girl's first dance of the evening may be her last if she's guilty of underarm odor. That's why it's wise to go places with Mum and stay nice to be near.

Mum

I TUN

better because it's Safe

1. Safe for skin. No irritating crystals. Snow-white Mum is gentle, harmless to skin.

2. Safe for clothes. No harsh ingredients in Mum to rot or discolor fine fabrics.

3. Safe for charm. Mum gives sure protection against underarm odor all day or evening.

for Sanitary Napkins. — Mum is gentle, safe, dependable . . . ideal for this use, too.

Special to Public Health
Nurses: Mum's Per-

sonal Grooming
programme now
includes "Grooming For School"
charts and leaflets.
Write for your copy.

Product of Bristol-Myers Company of Canada I td. 3035 St. Antonic Street, Montreal 30, Que.



Personality plus longer life. The Gilbergs of Ottawa bought a duck to fatten up for a Sunday dinner. But the duck had personality. He caressed the boss with his beak, went swimming with the kids, got housebroken. Result: ducked the roasting pan.

Novel switch. Six Boston housewives were fined \$10 each for playing poker on Sunday. The complainants—their husbands.

Double take. Beatrice and Dorothy Senkoff, sisters, married Robert and Murray Berken, brothers, two years ago. They lived in the same apartment house. Recently, they went to a hospital in the same ambulance and gave birth to daughters. All six Berkens are fine.

The wayward tailor. An Ontario tailor had been missing, and nervous customers began to wonder when they would get their suits back. Meantime, the Police and Fire Chiefs took turns in the tailor's shop returning the goods. The search ended when police announced he was located in the Hamilton jail. He's doing 30 days on a drunkenness conviction.



"Il Tho was here prest?"

JUNE, 1947

UNIVERSITY OF TORONTO SCHOOL OF NURSING

Session 1947-48

- I. The Basic or General Course in Nursing: 5 years (43% calendar years) in length; leads to Degree of B.Sc.N. and gives also a qualification for general practice in public health nursing; qualifies fully for nurse registration. The candidate remains as a student in her University School throughout the entire course (with practice in the wards of the surrounding hospitals). The entrance requirement is senior matriculation (Ontario Grade XIII).
- II. Courses for Graduate Nurses: (Entrance requirement: Junior Matriculation). These are one-year Certificate courses as follows:

Nursing Education: General (preparation for teaching).

Nursing Education and Administration: An advanced course.

Public Health Nursing: General.

Public Health Nursing: Advanced courses in Administration and Supervision, or other specialty.

Clinical Supervision in:

- (a) Medicine
- (b) Surgery
- (c) Obstetrics
- (d) Paediatrics
- (e) Operating-room procedure
- (f) Psychiatry or other specialty as selected.

Note: In Clinical Supervision the student chooses one of the above as her field of study for the entire year.

III. A Special Arrangement for Graduate Nurses: Whereas a candidate with senior matriculation standing may register in the Faculty of Arts of this University and complete the Pass course in Arts in 3 years, and, whereas some of the subjects of this Pass course in Arts are identical with certain subjects included in the above Certificate courses, it has been arranged that a graduate nurse who registers in this Pass course in the Arts Faculty may register at the same time in this School and, during the same 3 years, cover the requirements for the Certificate in one of the courses as described above, except that the courses in Clinical Supervision are not included in this arrangement.

For information and calendar apply to:

THE SECRETARY

Vision Tests

In the school health programs in Ontario, vision tests are carried out on:

- 1. All pupils on admission to school.
- 2. Pupils in Grade IV and other children in the age group 9-10 years annually.
- 3. All pupils before leaving elementary school.
- 4. All pupils known to have defective vision, annually, whether or not glasses have been prescribed.
- 5. Individual pupils brought to the attention of the nurse at any time by the parent, teacher, or other interested persons.

Book Reviews

Essentials of Pediatrics, by Philip C. Jeans, M.D., Winifred Rand, R.N. and Florence G. Blake, R.N. 627 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 4th Ed. 1946. Illustrated — 9 in color. Price \$3.75.

Reviewed by Patricia Raymond, Supervisor, Pediatrics Department, Royal Victoria Hospital, Montreal.

This text is one which any student of pediatrics knows well. Now, with the addition of a new author, and the insertion of several new chapters, it becomes a *must* in every hospital library, and in the collection of everyone dealing with the nursing of children in any capacity. The new chapters give the book added interest as well as much advanced information on current topics of study.

This fourth edition, as were its predecessors, is in the curriculum for schools of nursing prepared by the National League of Nursing Education. Now presented in unit form, double column with functional running-heads. it makes for clearer and easier study. There has been included more nursing care, also added chapters on diseases of the blood, of the eye, and the glands of internal secretion, in an interesting and comprehensive manner. The wider interpretation of skilful nursing techniques is given some thought. In the opinion of this reviewer, this will be of immeasurable value to those not coming in contact with the more uncommon conditions found in general pediatric nursing. The most



Phillips' Milk of Magnesia

can be prescribed in cases where mild laxative and gastric antacid action are indicated as in

CONSTIPATION PEPTIC ULCER

COLDS

As a laxative: gentle and smooth-acting without embarrassing urgency.

As an antacid: Contains no carbonates, hence no discomforting bloating. Affords effective relief.

DOSAGE:

Laxative: 2 to 4 tablespoonfuls

Antacid: 1 to 4 teaspoonfuls, or

1 to 4 tablets

PACKAGING

Liquid Tablets
4 oz. bottle box of 30's
12-oz. bottle bottle of 75's
26-oz. bottle bottle of 200's

PHILLIPS' MILK OF MAGNESIA

prepared only by THE CHAS. H. PHILLIPS CO. DIVISION of Sterling Drug Inc., 1019 Elliott St. W., Windsor, Ont.

advanced information and methods of treatment are concisely and accurately presented.

Another feature, a part of nursing often overlooked or mishandled, is the adept manner in which nurse-child relationships are interpreted. These are introduced at intervals throughout the book as well as having a chapter devoted entirely to the "child and the admitting office," etc.

Excellent illustrations, particularly demonstrations of the various restraints in use, complete the text and make it a good one to have on your nursing library shelves.

Practical Nursing. An analysis of the practical nurse occupation with suggestions for the organizations of training programs. 144 pages. Published by Federal Security Agency, Office of Education. For sale by the Superintendent of Documents, Washington 25, D.C. 1947. Illustrated. Price (in U.S.A.) 55 cents.

Under the auspices of the Vocational Education Division of the United States Office of Education, a representative and highly qualitied group of persons has drawn up the most detailed analysis of the activities and requisite training of practical nurses that has yet been prepared.

"The analysis . . . represents the best professional judgment . . . regarding the nature of the job of the practical nurse and the skills and knowledge which she should possess in order to work effectively in her occupation without endangering her own safety or the safety of the general public."

The practical nurse is defined as "a person trained to care for subacute, convalescent, and chronic patients requiring nursing services at home or in institutions, who works under the direction of a licensed physician or a registered professional nurse, and who is prepared to give household assistance when necessary."

The analysis outlines, with meticulous care, what the practical nurse must be able to do; what she must use in the way of equipment and supplies; what she must know. Deliberately, no specific suggestions regarding curricula for schools of practical nursing are included in this outline. Nevertheless, this available information should be valuable as a guide to all of those persons who are engaged in the training or supervision of practical nurses. The registered nurses who are concerned with the problems related to the licensure of this group will find the analysis very helpful in setting up standards.

Holiday . . .

IN THE LAURENTIANS!

The Victorian Order of Nurses' Summer Residence

THE PAULINE LEMOINE MEMORIAL

situated on Blue Sea Lake in the Laurentian Mountains, 80 miles north of Ottawa, affords a splendid opportunity for a real rest, as well as a most enjoyable holiday at very reasonable rates.

Good meals. Good bathing beach for either beginners or full-fledged swimmers. Hot and cold running water. Very large living-room with boulder fireplace. Hot air heating for the cool mornings and the late Fall evenings. Nurse guests have the privilege of introducing friends.

Situated on a splendid motor highway from Ottawa along a most picturesque route. Railway Station, Messines, Quebec.

Reservations should be made as early as possible in order to ensure accommodations as we had to refuse many last season.

Write to:

MRS. W. B. MacDERMOTT, 216 METCALFE ST., OTTAWA, ONT.

Illustrations of Anatomy for Nurses, by E. B. Jamieson, M.D. 64 plates plus index. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macimillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1946. Price \$2.00.

Reviewed by Isabel Lane, Instructress, Victoria Public Hospital, Fredericton, N.B. Several of the illustrations in this book should be of value to the instructor, and could be used to supplement the material in the anatomy and physiology texts: e.g., the upper surface of the base of the skull, showing the position of the inner ear; the section of the eyeball; the coronal section of the vagina, uterus, and uterine tube; the vessels and nerves of the superior mediastinum.

The illustrations are brightly colored and carefully labelled. A few might be too complicated for the student, but most of them should be simple enough to be very helpful.

If the book were about four times as large and had a stiff cover, it would be much more useful for classroom demonstration.

Katharine Kent, by Mary S. Gardner, A.M., R.N. 298 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1946. Price \$2.75.

"Remember that, however rough the road,

if your wagon is hitched to a star, as it must needs be if you are to fulfil your true destiny, failure is impossible — for the pull of a star is the most powerful thing known for those who are willing to entrust themselves to its impelling force."

The star to which Katharine Kent hitched her wagon on her graduation night and how its beacon light guided her through thirty years of strenuous activity in public health nursing is interestingly and stirringly told in this novel by Mary Gardner, the tried and true friend of public health nurses the world over. Miss Gardner assures us the book is neither a biography nor an autobiography. That matters not a whit. What is of significance is the vital picture she has portrayed of the growth and development of this branch of nursing in the United States during a quarter of a century. As a source of inspiration to student nurses, to young nurses in their first adventures in public health nursing, to supervisors and administrators, the story unfolds with conviction and the sure touch of an understanding leader.

Katharine Kent's early, baffling struggles in a single nurse district, her growth in a large organization, her courage in the face of physical injury that threatened to wreck her professional activity, her rise to positions of responsibility and leadership are interwoven with warm colors of friendship and affection. In no sense a textbook, the story teems with illustrations of the right kind of objective thinking which has been an intrinsic part of the contribution the leaders in public health nursing have made. You will enjoy reading it!

Manuel des Questions et Réponses d'Examens des Gardes-Malades. Compilation de Mlle Charlotte Tassé de la revue, La Garde-Malade. Revision de Rév. Soeur Paul du Sacré-Coeur des Soeurs de la Providence et de Mlle Laguë de l'Hôpital St-Luc. 1264 pages. Publié par Les Editions Lumen, 494 ouest, rue Lagauchetière,

Revue par Suzanne Giroux, Visiteuse officielle des Ecoles d'Infirmières, l'Association des Infirmières de la Province de Québec.

Montréal 1, 1946. Prix \$5.75.

Les manuels de questions et réponses ne sont pas bien vus ordinairement en milieu pédagogique. L'élève peu studieuse au lieu de s'en servir comme aide mémoire ou pour récapituler une matière, se fie sur un de ces manuels pour passer des examens sans avoir approfondi ses matières.

Après avoir lu ce manuel de questions et réponses, j'en suis venue aux conclusions suivantes: ce livre peut rendre de grands services lors de la récapitulation de certaines matières. Les tableaux synoptiques, les différents caractères d'imprimerie, la disposition montrent bien l'expérience pédagogique des personnes ayant eu la charge de la revision.

Toutes les parties du livre à mon avis n'ont pas la même valeur — la plupart sont excellentes, quelques-unes plus faibles. Il est difficile qu'il en soit autrement dans un livre de ce genre. Il en est de même pour certains traitements indiqués dans ce livre — préconisés par certains médecins, ils peuvent être condamnés par d'autres.

L'élève devra toujours analyser ces réponses et voir si les principes du nursing sont à la base de ces traitements. Pour la première fois il y a des questions et réponses en chimie, c'est simple et clair. Pour conclure je dirai que ce manuel est plus qu'un aidemémoire; il est en quelque sorte une synthèse du cours théorique de l'informère Ce manuel témoigne des progrès réalisés dans l'enseignement aux informières; si la guerre en a retardé l'apparition, ce retard nous a peut-être valu un tenut plus min



From the very beginning Baby's Own Soap, Oil and Powder were designed to be the *really gentle* toiletries a baby's tender skin requires.

are especially prepared

Only pure, carefullytested ingredients are contained in Baby's Own Toiletries . . . based on 75 years of continuous research and experience.



for baby's tender skin



You can safely recommend these extra pure, extra gentle toiletries for any baby. They're worthy of your complete confidence.



The J. B. WILLIAMS CO. (CANADA) LIMITED

La Salle, Montreal

LOANS

The Canadian Nurses' Association is prepared to make loans, up to a maximum of \$500, to any nurse in Canada, who is in good standing in her provincial registered nurses' association, to enable her to undertake post-graduate courses in nursing.

The loans are interest free for first three years; five years allowed in which to repay loan.

For full particulars and application forms, apply to:

CANADIAN NURSES' ASSOCIATION
1411 CRESCENT STREET
MONTREAL 25, QUEBEC

SCHOLARSHIP AWARD

The Alumnae Association of the Kingston General Hospital is pleased to announce that a Scholarship will be awarded this year, covering \$500, to a member who has had at least one year's experience and who wishes to do post-graduate study.

Please state course desired and make application to:

Miss Ann Davis, Sec. Nurses Alumnae General Hospital Kingston, Ontario

Note that applications will be received until July 31, 1947.

Nursing Sisters' Association

At a recent meeting of the Kingston Unit, the following officers were elected; President, Dorothy Riches, R.R.C.; vice-president, Ruth Peck, A.R.R.C.; secretary-treasurer, Grace Froats. Two hundred and fifty dollars was donated to the War Memorial Trust Fund. V. Hora was the unit representative at the International Congress of Nurses held at Atlantic City.

Toronto Unit: Through the kindness of Doris Kent, of Christie St. Hospital, a successful bridge was held at the nurses' residence, when forty tables were played. One hundred and twenty-five nursing sisters of World Wars I and II were present and approximately two hundred dollars was realized for the British Nurses Relief Fund. Receiving with Miss Kent were, the president, Ethel Greenwood; the past president, Mrs. G. Storey, and the social convener, Helen Howe.

At the annual meeting of the Toronto Poppy Fund a certificate was presented to the unit. Mrs. M. R. Carroll, convener of the Poppy Day Committee, is making plans for assisting with the annual Poppy Day.

The Thursday Red Cross group, which served all through the war, is still carrying on by making surgical dressings for out-post hospitals.

Ontario

The following are staff appointments to and resignations from the Ontario Public Health Nursing Service

Appointments: Florida Dupuis (Ontario Hospital, Hamilton; St. Joseph's Hospital, Hamilton; University of Toronto School of Nursing) as supervisor of public health nursing with Prescott and Russell health unit; Dorothy Adams (Winnipeg General Hospital: Toronto and McGill Universities) as supervisor of public health nursing with Lennox and Addington health unit; Kathleen Lyne (Hospital for Sick Children and University of Western Ontario certificate course) to Galt Board of Health; Margaret Nicol (University of Toronto diploma course) to Lambton health unit; Norma MacPherson (Toronto General Hospital and University of Toronto certificate course) to North York Township Board of Health.

Resignations: Madonna (Hurtubise) Richer (St. Michael's Hospital, Toronto, and University of Toronto certificate course) from Peterborough Board of Health. More than thirty thousand veterans and widows of those who were on active service are receiving benefits under the War Veterans Allowance Act.

News Notes

ALBERTA

Once again the Division of Public Health Nursing of the Alberta Department of Public Health opened the spring season with its annual staff conference. Approximately fifty nurses attended, including District and Child Welfare Clinic personnel and, from April 8 to 10, the problems, both individual and collective, of the Division received a vigorous airing under the chairmanship of Director Jean S. Clark. Topics included in this year's program were: Dental problems of district nurses; handling of retarded children in home and school; rat surveys in western Canada; care of rheumatic fever cases in the home; work of the Council of Social Agencies; newer drugs; student field experience; nutrition surveys.

Included also on the agenda was the distribution of a new "Manual for Public Health Nurses," recently prepared as a general guide to the district nursing service in Alberta. Outlined in it are the history of nursing services under the Department of Public Health, the personnel policies of the Division, and a tentative program outline for the

nurses in the field.

EDMONTON:

Royal Alexandra Hospital:

Mrs. W. Bowker was an interesting guest speaker at a meeting of the Royal Alexandra Hospital Alumnae Association, with the president, Mrs. N. Richardson, in the chair. Her topic was "The United Nations Society of Canada." Members were reminded that a shower of gifts for the bazaar would be held later on in the year.

MANITOBA

BRANDON:

At a recent meeting of the Brandon Graduate Nurses' Association plans were furthered for the raising of funds for the War Memorial Trust Fund, which has been established for the purpose of rebuilding libraries in schools of nursing in war-devastated countries. Mmes H. McKenzie and S. Durnin reported on the scholarship dance. Mrs. Jean Fargey's group was in charge of the program which included a showing of the program which included a showing of the young men's section of the Board of Trade. Mrs. E. H. Hannah presided.

UNIVERSITY OF ALBERTA

School of Nursing

•

The following one-year courses are offered to Graduate Nurses:

- 1. PUBLIC HEALTH NURSING
- 2. TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
- 3. ADVANCED COURSE IN PRACTICAL OBSTETRICS

For information apply to:

Director of Nursing University of Alberta Edmonton, Alta.

UNIVERSITY OF

Post-Graduate Courses for Nurses

The following one-year certificate courses are offered in:

- 1. PUBLIC HEALTH NURSING
- 2. TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
- 3. ADMINISTRATION IN SCHOOLS OF NURSING

For information apply to:

Director

School of Nursing Education University of Manitoba Winnipeg, Man.



Nursing Textbooks

Every year more Canadian hospitals are using the two excellent text-books listed below. Both contain the latest advances in nursing and both are arranged for the greatest convenience of instructors and students.

MEDICAL NURSING

By Edgar Hull and Cecilia M. Perrodin. 641 pages. 152 illustrations, including 10 colour plates and 38 charts. Third edition, 1946. \$4.00.

SURGICAL NURSING

By Robert K. Felter and Frances West. 589 pages. 252 illustrations and 7 colour plates. Fourth edition, 1946. \$4.00.

THE RYERSON PRESS

THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing, with or without experience.

Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Miss Maude H. Hall Chief Superintendent 114 Wellington Street Ottawa.

NEW BRUNSWICK

MONCTON:

At a well-attended meeting of Moncton Chapter, N.B.A.R.N., Dr. George Parsons, anesthetist, addressed the members and demonstrated the new adult oxygen tent which has been donated to the hospital by the Nurses Hospital Aid. A box of food has been sent to the Dutch nurse adopted by the chapter. The St. Patrick's Day dance proved a great success.

SAINT JOHN:

A very successful telephone bridge was held by the Saint John Chapter, N.B.A.R.N. At the April meeting, Dr. Jean Webb, chief nutritionist with the New Brunswick Department of Health, gave an interesting talk on the science of nutrition and how this branch of health work is being developed in the province. Plans were made to send blankets to the Rest-Breaks Home at Barton-on-Sea, England, also for the annual vesper services to be held in Saint Mary's and in the Roman Catholic Cathedral.

The regular monthly meeting of the Public Health Section of the Saint John Chapter was held in the Y.M.C.A. on April 9. It took the form of a supper party in honor of Mrs. Olive Guilfryle who has retired from the staff of the V.O.N. The honor guest was presented with a lovely silver bracelet by Miss E. Barry on behalf of the members. Miss Ruth Thompson who has been recently added to the staff of the Child Welfare nurses was welcomed. Miss Thompson is a graduate of the Saint John General Hospital.

A letter of thanks was read from Miss Gertrude Ford our overseas nurse. Miss Margaret Pringle volunteered to send our overseas box this month.

The Saint John General Hospital Alumnae met in the Lecture Room, Nurses Residence

with Miss Bea Selfridge presiding. Plans were made for the dinner dance and bridge to be held in the Admiral Beatty Hotel on June 11, in honor of the 1947 graduating

class.

Miss Agnes D. Carson recently resigned from the staff of the Saint John Tuberculosis Hospital ending 53 years of active nursing service, having graduated from the Saint John General Hospital in 1894. Miss Carson received from the staff of the hospital a well-filled purse with the best of wishes on her retirement. Patricia Carson is now a patient at the Sanatorium, River Glade. Katherine Kincaide, of the staff of the Vancouver Unit of Tuberculosis Control, spent a month visiting in Saint John. Marion Myers, president, and Alma Law, secretary, N.B.A.R.N., attended the C.N.A. executive meeting in Montreal. Mrs. Fred Sterling (Frances Munroe) has recently taken up residence in Winnipeg, moving there from Calgary. Maryon Barker has accepted a position in Dr. George Skinner's office. Mrs. Handreer

VOLUME 43 NUMBER 7 MONTREAL JULY 1947

THE CANADIAN NURSE



Nursing Care of Urologic Patients

by Dr. C. A. Cawker

New Methods of Treatment for Gonorrhea

by Dr. B. D. B. Layton



What Next?



OWNED AND PHRIISHED BY



had on duty, the Government would probably have a brand new class of capitalists to tax. Every nurse, however, realizes that it pays big dividends to obtain rapid symptomatic relief by the use of a tested and effective analgesic.

Tabloid' Brand 'Empirin' Compound is just such a preparation. Its formula has won virtually universal approval for its effective analgesic action, while the purity of its ingredients and careful compounding ensure a rapid, dependable effect. For a trial sample, simply tear out and mail the sample offer below.

Each product contains

'EMPIRIN' (Brand of Acetylsalicylic Acid) gr. 3½
PHENACETIN gr. 2½
CAFFEINE gr. ½

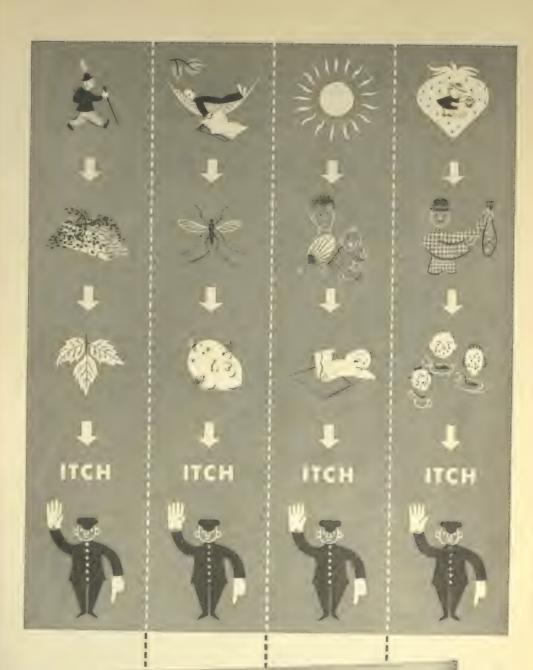
TABLOID BRAND TRACE MARK

Please send me without obligation a sample issue of 'Tabloid' Brand 'Empirin' Compound.

Name

Address





CALMITOL

The Leeming Miles Co. Lid.
I NOTRE DAME ST. W., MONTREAL I, CANADA

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR JULY, 1947

VACATION THOUGHTS	511
THE CANADIAN NURSES' ASSOCIATION IS INCORPORATED	512
NURSING CARE OF UROLOGIC PATIENTS	514
Prostatism	522
NEW METHODS OF TREATMENT FOR VENEREAL DISEASE — GONORRHEA	
B. D. B. Layton, M.D.	526
WITH UNRRA IN GERMANY	532
THE ORIENTATION OF NURSES	533
EMPLOI DU B.C.G	537
THE CANADIAN CITIZENSHIP ACT ANALYZED	539
THE MEMORIAL AT OTTAWA	541
Notes from National Office	544
Notes du Secretariat de l'A.I.C.	548
GASTRIC ULCER	557
THE RESUSCITATION OF THE DROWNED	560
News Notes	563

SAVE MONEY! Buy Ahead for 3 Years

For many months we have been facing the question of advancing our subscription rates to help counteract the increasing costs of publishing *The Canadian Nurse*. Because we were anxious to do our share against the rising prices all along the line, we have postponed this step as long as possible.

It has become evident that we can no longer continue to give you the high quality of service which you have come to expect, at the subscription rates which were originally set in the '20's. Rather than sacrifice any standard of the *Journal*, the increased rates will be put into effect on October 1, 1947. However, this increase in the cost of subscription need not affect you for several years to come. Before the new rates become effective, you have the opportunity to buy *The Canadian Varies* ahead at the present low prices. You matter how far in advance your

dian Nurse ahead at the present low prices. No matter how far in advance your subscription is already paid up, you may purchase another three years for five dollars if you subscribe promptly.

It will be gratifying to know that you need not be bothered with year-after-year renewal notices — to know that you are receiving outstanding value for your dollars — to know that you will receive your copy of *The Canadian Nurse* regularly.

Until October 1, 1947, the subscription rates for the *Journal* are: \$2.00 per year; \$5.00 for 3 years; foreign and U.S.A., \$2.50 per year; student nurses: \$2.00 for eighteen months; \$4.00 for three years.

All cheques, money orders and postal notes to be made payable to *The Canadian Nurse*. Add 15 cents exchange to personal cheques. Please PRINT name and address to ensure accuracy.

Vol. 43, No. 7

Brand of chorionic gonadotrophin in





- * potent
- * economical
- * painless on injection

For the treatment of cryptorchidism, Frohlich's syndrome, hypogonadism, menorrhagia and metrorrhagia.



AYERST, MCKENNA & HARRISON LIMITED

Biological and Pharmaceutical Chemists . MONTREAL, CANADA

Reader's Guide

Urological diagnosis and treatment have reached a degree of exactness and precision which demands a high level of skill on the part of the nurse who is assigned to this branch of the service. It is true that a great many of the details of care will be performed by the surgeon himself, an interne, or an orderly. Nevertheless, there are many factors in the care of both pre- and post-operative urological cases which are the direct responsibility of the nurse. Dr. Charles A. Cawker, who is urologist at Shaughnessy Hospital, Vancouver, has outlined these nursing responsibilities clearly Supplementing Dr. Cawker's and fully. advice, we present specific details of the nursing care which is applicable to the various types of operative treatment for prostatism. Evelyn Myers is the supervisor of the urological department at the Victoria General Hospital, Halifax.

Those of you who read Dr. B. D. B. Layton's analysis of present-day treatment methods for syphilis in the March, 1947, issue, will be greatly interested in his companion article on the treatment of gonorrhea which is presented here. The appalling increase in the number of cases of this disease has caused deep concern. However, the use of the antibiotics promises a more swift and complete cure. Dr. Layton is chief of the Division of Venereal Disease Control in the Department of National Health and Welfare.

Last month we had planned to bring you this excellent interpretation of the Canadian Citizenship Act. Somehow our space was all filled up so this material had to be hoisted to this issue. Reading this material in conjunction with the abovementioned article, perhaps it will dawn on us that, though we may swell with pride at the realization that we may call ourselves Canadians before the whole world, citizenship implies certain obligations which many women are prone to shirk.

The Committee on Public Health Nursing is combining forces with the French page this month in the analysis of present-day use of B.C.G. to combat tuberculosis. Georgine Badeaux is assistant director of the medical-social service of the Bruchési Institute for Tuberculosis in Montreal. A condensation

in English is appended for those public health nurses who are unable to read the original article.

The Committee on Institutional Nursing is devoting most of its special pages this year to the consideration of various aspects of personnel practice. Last month a general discussion of the technique to be used in the introduction of new nurses to hospital staff paved the way for this detailed description of how it is being done in a specific situation. Margaret M. Street has occupied the position of ward instructor at the Ross Memorial Pavilion, Royal Victoria Hospital, Montreal, for a year and a half. In that time, a large number of nurses, both students and graduates, have benefitted from her orientation program. Prior to this work, Miss Street was executive secretary of the Manitoba Association of Registered Nurses.

Lyle M. Creelman had the unique opportunity of serving as chief nurse with the UNRRA mission when it was first organized in Germany. Her documentary report on conditions among the civilians of Germany, the Displaced Persons, the problems of reorganizing the health facilities, including hospitals, and the progressive steps taken to provide anything approaching adequate nursing service makes very interesting reading. The first instalment of this report is presented herewith. It will be concluded next month.

There are many medical terms applied to various conditions of the circulation but we cannot find one that suits our particular problem. What would you call "growth of the circulation?" Anyway, here are the figures for the number of copies for June, 1947, issue, by provinces: Alberta, 837; British Columbia, 1,198; Manitoba, 420; New Brunswick, 601; Nova Scotia, 535; Ontario, 3,438; Prince Edward Island, 106: Quebec, 1,060; Saskatchewan, 592.

Christopher Chisholm, our "sun baby" on this month's cover, is the healthy, happy son of Mr. and Mrs. H. C. Chisholm of Westmount, P.Q. Christopher, like all active little boys, would sooner get into mischief than eat. Here he pauses for a jiffy to consider what to do next.



Tubex *

PENICILLIN IN OIL AND WAX (ROMANSKY FORMULA)

Now available in the safe, convenient container for injection with the Tubex syringe

- · Most cases of gonorrhea arc cleared up by a single injection.
- Pneumococcal, streptococcal and staphylococcal injections usually respond to one or two Tubes per day.
- Therapeutic blood levels are maintained in most patients for twenty-four hours.

The Tubex assembly combines convenience with safety

. . . By exerting negative pressure (withdrawal) it is easy
to make certain that a blood vessel has not been entered
prior to injection.

Packages of 6 Tubes, I or ease, with Tubes assinge and 6 Tubes needles.

Each Tubes contains a single-dose of 500 000 international units of direct
permullin calcium in peanut of with 4.8. because Single Tubes with
needle are available. Directions with each package.

* Irade Mark Reg in Canada

JOHN WYETH & BROTHER (CANADA) LIMITED . WALKERVILLE, ONTARIO

They look to you, Doctor..

"It has to be considered whether the damage to tissues, whether gross or only microscopic, will outweigh the advantage possibly gained by killing bacteria; some antisepties are caustic or irritant, others comparatively bland." Garrod, L.P., and Keynes, Geoffrey, L. (1937 Brit. Med. J., 2, 1237)

You, in choosing an antiseptic for the prevention, or chemotherapeutic for the treatment, of an infection, have knowledge and experience to guide you. But what of the unskilled person using an antiseptic at home! What does he know of this important consideration! Nothing, or next to nothing at all.

YET HERE is the crucial problem of all antisepsis; most acute, obviously, with antiseptics which are toxic at all bactericidal strengths; progressively less acute as the margin widens between the bactericidal dilution and the dilution at which toxic effects first appear.

consider now an antiseptic with which the problem hardly arises at all. One which, though bactericidal in considerable dilution, is bland at any strength. One which may be applied direct to the tissues without risk of either injury or interference with natural healing processes. Such a non-poisonous antiseptic is 'Dettol.'

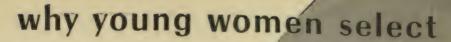
MOREOVER, and most importantly, 'Dettol' has low selectivity. It is rapidly lethal

to a diversity of pathogenic organisms, including Strep.pyogenes, Staph.aureus, B.coli, B.typhosum, and such wound contaminants as B.proteus and Ps.pyocyanea, And it remains active under clinical conditions, i.e., in the presence of blood, pus and tisque debris.

ADD TO THESE remarkable properties that 'Dettol' is pleasant to smell and agreeable to use, and that it does not stain either linen or the skin, and it will be seen that here is an almost ideal antiseptic for general use in Canadian homes, as it already is in millions of homes in other parts of the Empire.

'DETTOL' OBSTETRIC CREAM is a preparation of 30 per cent. 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against re-infection by haemolytic streptococci.

RECEITT & COLMAN .CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL MIS



TAMPAX

Fortunate indeed is the young girl of today who learns about the TAMPAX method of intravaginal protection almost from the time of her first menses. She will enjoy greater freedom, safety, comfort and daintiness 1,2,3,4 throughout her periods, and need never experience the drawbacks of older methods of protection.

In several large cities, for instance, every high school girl was recently taught the TAMPAX method of hygiene—and in literally hundreds of leading schools and colleges TAMPAX is recommended in physical education and home economics courses. In many units of the youth clubs also, instructions are freely given in the TAMPAX technique.

The Junior absorbency of TAMPAX (easily introduced without apertural strain) is usually favored by younger women—though Regular and Super absorbencies are also available. May we send professional samples?

REFERENCES: (1) West. J. Surg. Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943; (4) Am. J. Obst. & Gyn., 48:510, 1944.

TAMPAX

Canadian Tampax Corporation Ltd., Brampton, Ontario.

Send in the send professional serges.

Send educational material for ... students.

(Please print)

117 PROV. P7 20

Accepted for Advertising by the Journal of the American Medical Association

JULY 1947

ANNOUNCING the return of HEINZ JUNIOR FOODS

After several years of absence, due to shortages and restrictions, Heinz is again producing, in fair quantity, a range of 12 varieties of Junior Foods.

These foods have added nutritive value through the inclusion of special ingredients such as wheat germ, soy bean flour, dried brewer's yeast and whey powder, containing lactose, milk minerals and vitamins.

The medical profession can recommend these products no less confidently than Heinz Baby Foods. Both are backed by a 78-year record of quality food preparation.

JUNIOR FOODS NOW AVAILABLE

CREAMED DICED VEGETABLES
LAMB AND LIVER
CARROTS
SPINACH
MIXED VEGETABLES
PRUNE PUDDING

VEGETABLE BEEF DINNER
GREEN BEANS
APPLE, FIG AND DATE DESSERT
PINEAPPLE RICE PUDDING
CHICKEN SOUP
TOMATO AND RICE

HEINZ STRAINED FOODS



HEINZ JUNIOR FOODS



Johnson's DRAX means less laundering . . . easier laundering!

Here is a completely new and different laundering aid . . . Johnson's DRAX. Not a starch, not a soap, DRAX is an invisible wax rinse that protects fabrics from dirt, soil and water! They stay clean and fresh-looking longer . . . and they're easier to wash!

DRAX... made by the makers of Johnson's Wax... may be applied to any washable fabric: uniforms, curtains, tablecloths, bedspreads. It is easy and inexpensive to use. You need no special equipment or special skilled help. Yet it cuts down on washing time, on washing frequency, on washing costs!

Any institution or concern that uses large quantities of washable fabrics in their equipment will find that it pays to use DRAX. Why not find out about DRAX today!

DRAX

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

JULV, 1947 508

Readily Digestible MILK MODIFIERS for INFANT FEEDING

Crown Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.



"CROWN BRAND" and "LILY WHITE" CORN SYRUPS

Manufactured by THE CANADA STARCH COMPANY Limited
MONTREAL AND TORONTO

WANTED—INSTRUCTORS FOR SCHOOL OF NURSING

- INSTRUCTOR IN NURSING ARTS
- INSTRUCTOR IN SCIENCE

Two Registered Nurses are required to instruct in the above General Nursing subjects at Brandon Mental Hospital, affiliated with the Winnipeg General Hospital. Class under instruction all possess Junior Matriculation standing, and are taking combined course in Mental and General Nursing.

Salary schedule: \$150 to \$175 a month, less \$25 for full maintenance (board, laundry, uniforms, and an attractive room in the Nurses' Home.) Full Civil Service benefits — three weeks' annual vacation with pay, sick leave with pay, Superannuation Fund, etc. Apply, stating experience, date and place of graduation, etc., to:

MANITOBA CIVIL SERVICE COMMISSION
223 Legislative Bldg., Winnipeg





Trushay's beforehand protection offers preventive action before hands are damaged. Before washing hands, apply Trushay. An invisible film is formed over skin tissues which helps guard against the harsh effect of washings and cleansing agents. Trushay applied beforehand is widely used by professional men and women to aid in replacing natural oils and help keep dermal tissue soft and pliable. Trushay, the beforehand lotion, is well adapted to the needs of the physician, dentist and nurse.



The Beforehand Lotion

ion i

Product of Bristol-Myers Company of Canada I td. 3035 St. Antoine Street, Montreal 30, Que.



He saw the light. A transient stopped over at a Salvation Army Citadel in Goshen, Indiana, for prayers and a free meal. He left this note: "I've fixed your light meter so it won't register."

It finally happened. "Duke", a puppy, nipped his owner Harold Whelan, age 7, of Cambridge, Mass., in the ankle. So down on all fours went Harold and bit Duke's hind leg.

Get thee behind me. The Pleasant Hill High School in Forreston, Ill. caught fire and the students organized a bucket brigade and extinguished the blaze. The temptation was great, they admitted.

farmhand of Napanee, Ont., trained a farm horse to assist him with his chores. Jankowski takes one end of a cross cut saw and the horse holds the other end in his teeth. No ordinary saw horse, Dobin and Jankowski cut quite a swathe.



"Hm-mm-n, my wat, has gained 10 minutes"

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to:

Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. O.

07

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. O.

THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

THREE-MONTH POST-GRADU-ATE COURSE IN THE IMMUNO-LOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS

is offered to Registered Nurses. This course is especially valuable to those contemplating public health, industrial, or tuberculosis nursing.

The course has been approved by the Registered Nurses Association of Ontario, the Director of the Department of Tuberculosis Prevention, and The Deputy Minister, D.V.A. Salary: 1st month—\$80; 2nd month—\$90; 3rd month—\$100—plus full maintenance.

For further information apply to:

Miss Ellen Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ontario

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

000

- One-Year Certificate Courses-

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses 1266 Pine Ave. W.

McGILL UNIVERSITY, MONTREAL 25

TORONTO HOSPITAL

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

THE CANADIAN RED CROSS SOCIETY QUEBEC PROVINCIAL DIVISION

NURSING OUTPOSTS TERMS OF EMPLOYMENT OF NURSES

Salary:

- 1. Registered Nurses with Public Health qualifications: \$1,500 per annum with annual increment of \$100 to a maximum of \$2,000 per annum.
- 2. Registered Nurses with Hospital or Private Duty experience only, \$1,380 per annum, with annual increment of \$60 to a maximum of \$1,800.

Maintenance:

Complete maintenance is provided by the Red Cross. At each of the six Outposts now operating in the Province of Quebec there has been completed or in process of construction a Clinic Centre with residential quarters for the Nurse or Nurses.

These buildings all have central heating, running hot and cold water, drainage, refrigeration, and wired for electric lighting.

Maintenance includes domestic help, food and lodging, drugs and supplies, and all the expense of operating the centre.

Transportation in the area is provided; in some areas by automobile in summer and/or by hired vehicle with driver.

Holidays:

One month away from the duty Post, approximately every six months, viz: two months in each year. One half of the two-month period to be spent in study or experience approved by the Red Cross Society. Should such a study period be taken at a centre which is not the holiday home of the Nurse, maintenance will be paid by the Red Cross.

Transportation to and from the Duty Post:

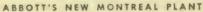
When first going on duty and subsequently at each holiday period the Red Cross Society will pay cost of transportation as between either Montreal or Ouebec and the duty Post.

For further information apply to:

The Canadian Red Cross Society Quebec Provincial Division 3416 McTavish St. Montreal 2, Quebec

JULY, 1947







This great new plant, conveniently located in Montreal, is visual evidence of our faith in our country's future

. . . From this plant will speed pharmaceuticals for our physician friends from coast to coast!

On the Cote de Liesse, Montreal, one of the finest pharmaceutical plants on the American continent has been erected. You, Doctor, have built this great modern plant! Your loyalty to Abbott, your strong preference for Abbott pharmaceuticals, through the years, have necessitated the erection of this up-to-the-minute structure.

So this is to say, simply and sincerely, "Thank you!" And to renew our pledge of devotion to your interests and to the welfare of your patients. With enlarged and improved facilities, and with strengthened personnel, we anticipate the privilege of serving you even more capably in days to come. And again ... thank you!

47-10B

Abbott Laboratories Limited

"CHANGING IDEAS + CHANGELESS IDEALS"

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER SEVEN

MONTREAL, JULY, 1947

Vacation Thoughts

Tноисн maintaining adequate staffs in hospitals and health organizations necessitates some of the nurses having earlier holidays, the time preferred by most nurses is during July or August. The boon of an annual vacation is one of the most precious perquisites of the personnel policies instituted for busy staffs. In most areas, at least three weeks' vacation is provided. Even better is four weeks. The growing tendency of many staff nurses to resign from their positions in order to have a whole summer off, is, of course, a sign of our times. With the existing demand for nurses all over the country, it is easy to find a new position when the long holiday is over. Unless this extended vacation is necessary from the point of view of overtaxed energy, it is a form of selfishness which should be strenuously discouraged. The probable result is that others, needing a change equally as much, have to forego or curtail their vacations in order to provide even partial coverage of the services.

What are you planning to do for

your holidays this month or next? No doubt your plans are well advanced. If you are going to any of the popular resorts, your reservations will have been made months ago. Seashore or mountain, dude ranch or fashionable hostelry, loafing or traveling—by air, rail, ship, bus or car—you are hoping for the best vacation you have had in years. Nevertheless, a word or two about the value of true recreation may help to make the holidays more enjoyable and the return to work less arduous.

Recreation is not limited to a few types of activity. It takes literally hundreds of forms from the most strenuous to those that require nothing more than sitting still and listening—to the surf pounding on the shore, the wind in the treetops, or the buzzing of bees in a clover patch. Vigorous exercise is an invaluable form of exercise in youth and useful when youth is past; but when middle age is reached, moderation in exercise is a form of insurance for more years to enjoy other recreations.

What ever form your recreation

JULY, 1947

takes, its primary purpose is to relieve mental and nervous strain, to help in recharging the human dynamo that is you, to give you a new zest for your work. In order that this re-creation may occur, it is wise to provide for a lull, a period of relaxing at the beginning of the holiday. At least two or three days of quiet relaxation will give you the necessary vim to launch out on your more exciting and vigorous plans. The same period of resting at the end of your holidays will bring you back on duty untired and well fortified for the next eleven months of work. To go hard during the whole period

results in strain which may tear down instead of building up your reserves.

You will get the greatest enjoyment and benefit from your vacation if you post a few "beware" signs where your mind's eye can see them. "Beware of poison ivy!" "Be careful of an overdose of sunshine!" Make up your own list. It should not be necessary to suggest such reminders to nurses but it is a curious commentary on our alleged knowledge and understanding of cause and effect that so many nurses adopt the attitude "it cannot happen to me!" It can and it does happen. Let us all try to make this summer an exception.

The Canadian Nurses' Association is Incorporated

Bill 171, an "Act to incorporate the Canadian Nurses' Association," has now become part of our history.

During the past ten years the question of incorporating the Canadian Nurses' Association has been considered frequently, both at executive and general meetings. In 1938 and 1940 it was decided to ask for incorporation, but in 1941 the matter was tabled. In 1945 the subject was reopened and in 1946 at the biennial meeting, following the adoption of a new Constitution and By-Laws, the following resolution was passed:



SENATOR N. M. PATERSON

That if on November 15, 1946, the majority of the total voting strength of the Canadian Nurses' Association have concurred either by voting or not voting thereon, in the adoption of the new Constitution and By-Laws, the Executive Committee of the Canadian Nurses' Association be instructed to apply for incorporation of the Canadian Nurses' Association by the Parliament of Canada.

Accordingly, when the prescribed



W. M. BENIDICKSON, M.P.

conditions were fulfilled and the new Constitution and By-Laws came into force on the 15th of November, 1946, our legal counsel, Mr. W. B. Scott, K.C., was instructed to apply for incorporation. The Bill was drafted and presented first to the Senate, and introduced by Senator Norman Paterson, of Ottawa, who gave the Bill his unqualified support.

A small delegation, consisting of our first vice-president, Miss Ethel Cryderman, Miss Agnes Macleod, Sister Hermine, of Hull, Miss Gertrude Hall, Mr. W. B. Scott, K.C., and Miss Eileen Flanagan, the convener of the Legislation Committee, was present when the Bill came before the Private Bills Committee of the Senate, and was graciously received.

The Bill was passed by the Senate on the 23rd of April, 1947. sponsor for the House of Commons was Mr. W. M. Benidickson, M.P., for Kenora, Ontario, who also gave it and us his attention and full support. It took a great deal of effort, also, on the part of our able counsel, Mr. W. B. Scott, K.C., our national and provincial officers, and many others to satisfy the members of the Private Bills Committee of the House of Commons, that we wanted the Bill in the form in which it had been adopted by our members. With a minor clarifying amendment, it passed the committee on May 21. On May the twentythird, nineteen hundred and fortyseven, it finally passed the House of Commons after being unanimously adopted on third reading.

As before, a delegation had appeared before the committee, consisting of the president, Miss Rae Chittick, Miss Ethel Cryderman, Rev. Sister Delia Clermont, Miss Agnes Macleod, Miss Nettie Fidler, Miss Gertrude Hall, Mr. W. B. Scott, and Miss Eileen Flanagan, and had been given every attention and courtesy.

Thus the unincorporated association, which has been doing such ex-



W. B. SCOTT, K.C.

cellent work during the past thirtynine years, has now been given legal status. By this Act of Incorporation, the Canadian Nurses' Association benefits by being officially recognized as a profession by the Parliament of Canada. It adds prestige and dignity to the association and, while providing an official way of co-ordinating the activities of the nine provincial associations who form its membership, it in no way interferes with the rights of the provincial associations, each of which is set up by an act of its own provincial legislature.

The Canadian Nurses' Association is our medium and spokesman in our relations with other national bodies, and with the International Council of Nurses. We are proud of another achievement in our history and thank all those who helped us so ably.

EILEEN C. FLANAGAN
Committee on Legislation,
Constitution and By-Laws

The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.

⁻ Constitution of The World Health Organization.

Nursing Care of Urologic Patients

CHARLES A. CAWKER, M.D.

PRE- and post-operative care of the urologic patient requires constant attention to detail by the nursing, orderly, and urologic surgical staffs.

Pre-operative care of the urological patient has been repeatedly emphasized during the past fifteen to twenty years and cannot be too greatly stressed. The present high standards of urological surgery have been achieved by the broader scope of our laboratories which enables them to give us all the essential laboratory as well as clinical information regarding the patient and to obtain the maximum improvement possible by non-operative means before

surgery is instituted.

Post-operative care is of the utmost importance in urologic cases, though it has not been as well emphasized to date. Discharge from hospital does not complete the program of post-operative observation and only the recognition of this fact will lead to more permanent as well as more satisfactory results. This necessitates regimens designed to prevent or diminish the recurrence of renal stones, hygienic treatment in tuberculosis patients, insistence on periodic urethral instrumentation in cases of urethral stricture, observation and correction of ureteral strictures in patients who have had ureterotomy or plastic operation on renal pelvis and/or ureter; continued vigilance over those with malignant or potentially malignant disease; the continued observation and follow-up care to the post-prostatectomy patient to clear the pyuria. Indeed, if at the end of the third or fourth postoperative month the patient continues to have a cloudy, infected urine, or has episodes of post-operative bleeding or recurrent sepsis, it is evident that he is suffering from persistent lesions which must be adequately treated. He requires rehospitalization for complete urologic examination and operation if necessary.

This prolonged observation and treatment, following many urological procedures, will at times produce permanent improvement in cases, which, without that continued interest, would lapse into a mediocre result.

Let me repeat and re-emphasize—pre- and post-operative care of the urologic patient demands constant attention to detail by nursing, orderly, and urologic surgical staffs. It implies also, by the urologist, careful scientific diagnosis, the accurate comprehension of the pathological condition present, and knowledge of the patient's most vulnerable spot for complications before decision is made as to a definite plan for surgical procedure.

The majority of our urologic patients are in the older age brackets and very many are classified as "poor risks." It is these latter who require urgent, but not often emergency, surgery to restore normal function and to return the patient to normal physiologic equilibrium as far as may be possible. The urologic patient who is "too old for surgery" is quite uncommon, but they do require painstaking, pre-operative care, good anesthesia, planned, gentle surgery, and careful, immediate postoperative care and later follow-up. The physiologic rather than the chronologic age is very important in this class of patient.

This preamble is to emphasize to you the importance of pre- and post- operative care in the urologic patient. I cannot stress this too much, as it is a fact that is too often not realized by the medical, general surgical and nursing staffs. It is the constant attention to apparently trivial details that can mean success or failure of the operative procedure, life or death to the patient. To give this added, but very necessary, service requires fewer patients per nurse than is usual on medical or general surgical wards.

Competent nursing in urology can

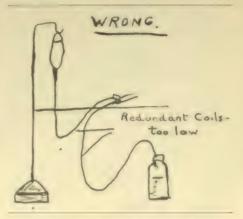
save time in hospital as well as add very greatly to the comfort of the patient. It is illustrated by constant attention to drainage tubes, especially in prostatic cases; promptly calling attention to and/or correcting catheters which are obstructed, adjusting tubing so that no tension is placed on the penile attachment of the catheter; watching for any kinks in the drainage system which are especially likely to occur with change of position by the patient; and attention to the hydrostatics of the various closed sterile irrigation systems commonly in use intermittent, continuous, and tidal systems—and the very important, diplomatic forcing of fluids. By forcing fluids we mean a fluid intake of 3000 to 4000 cc.-100 to 150 ounces -per twenty-four hours or roughly an eight-ounce glass of water per

To aid in this care, efficient equipment is a must and it should be as nearly foolproof as possible. Catheters should all be two-holed, soft rubber-F. 16, 18 and 20, hollow-tip and Coude types. Better still, use the Foley-type bag catheters which allow free drainage of any urethral discharge caused by the inlying catheter, thus lessening the likelihood of such complications as peri-urethritis and peri-urethral abscess formation, and epididymitis. All types should be kept clean at the urethral meatus and removed, cleansed, and replaced every 3-5-7 days. The Foley type may be left in situ up to two weeks with no detrimental effects. There is no place on the urologic ward (or any

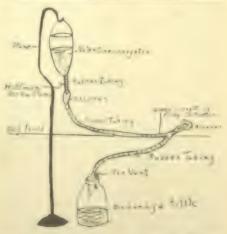
3. 1204R

No pende adit see necessary.

other ward) for catheters that are old, inelastic and soft, easily kinked or with a crack at the end necessitating unsatisfactory makeshift arrangements to connect them to drainage bottles. Suction through old urethral catheters is also quite impossible. Long, redundant coils of rubber tubing, too, are a hazard, but one



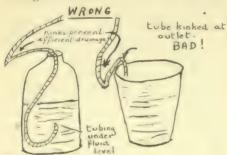
must be sure to have sufficient tubing to allow the patient freedom of movement. No rubber tubing is kinkproof, but new latex tubing is the least likely to kink. All tubing used should be new; old soft tubing is dangerous. Long loops of tubing should not be drooped below the bladder and bed level, as this requires additional pressure to force the irri-



Apparatus for continuous irrigation of bladder and for intermittent flushing and irrigation of bladder.

gating fluid up the loop into the bladder. Also, the tubing from the bladder should enter into a clean or sterile receptacle and the outlet of the tubing kept at the top, well above the water level. A pail or bottle may be kept on the floor at the bedside. The force of the siphonage is greater here but it is not sufficient to irritate the patient's bladder.

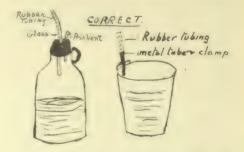
The tubing from the catheter to the drainage receptacle should not be allowed to sink below the level of its outlet. It requires more force or pressure to override this obstruction in order to drain the bladder contents. This means increased intravesical pressure with increased likelihood of vesical irritation; with reflux upper urinary tractinfection (pyelonephritis) or, in post-prostatectomy, it can stimulate renewed hemorrhage. Attention must also be paid to the tubing connected to the outlet vent.



A kink here has caused dire consequences as it completely, or almost completely, blocks the outlet with all the evil effects attendant on a distended bladder, to say nothing of the discomfort to the patient. Postoperative bladders have been ruptured by this accident. Even on the most modern and up-to-date urological services mistakes and accidents sometimes happen. It is for this reason that constant vigilance is the price of safety. "Urologic sense" can only be developed by plentiful experience in urologic surgery.

In all our irrigating systems we routinely use a dripper arrangement similar to that used on intravenous sets, or a Murphy dripper can be used. It is only by the use of some such arrangement that an accurate

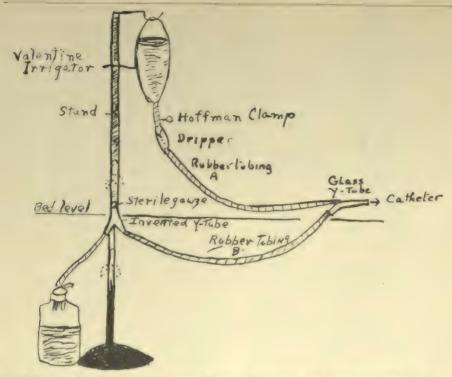
rate of flow can be determined at all times. The rate can easily be increased to flush out the bladder and as readily decreased to return it to the desired continuous irrigation rate. Unbreaching the sterile, closed circuit at the catheter inlet to the bladder to estimate the rate of flow is mentioned only to condemn it. It nullifies the sterile set-up and defeats part of the purpose of the closed circuit. Also, with the dripper arrangement, if all is not well in the bladder, the fluid often backs up into the system and it either stops altogether or slows it down. With the Murphy drip, unless the vent is sealed off, it will cause the water to leak out (for this reason I often close the opening with a piece of flamed adhesive). If this happens, it is a sign of trouble even though the irrigation otherwise appears satisfactory and drainage clear. Three conditions should be suspected:



(1) Clots in the bladder floor, even a few, foul up the inlet and are a cause of bladder spasms, which leads to increased bleeding, etc., plus the danger of chills and fever. This means reflux pyelonephritis has occurred. (2) Acute infection of the bladder. (3) Loop of tubing below bed level.

Treatment is to carefully investigate the status of the bladder by "milking" the tubing, intermittent irrigation and, finally, by unbreaching the outlet end of the catheter and doing intermittent bladder irrigation by means of a bulb or suction syringe.

In spite of these closed irrigation systems it is often necessary to disconnect the catheter outlet for intermittent bladder irrigations. Sterile technique must be observed:



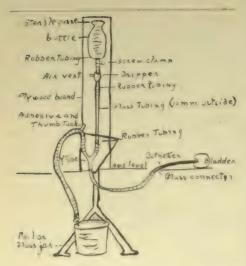
Closed system for drainage and irregation of bladder intermittent — manual control. For irregation: Pinch off tube B. Release clamp on tube A and allow desired amount to flow from irregator into bladder. Pinch A and release B to allow fluid from illuder to flow into drainage jur. Repeat until return flow clear. Dripper is not absolutely necessary for intermittent irregation but is required to convert to continuous or tidal systems. Y-tube in drainage conduct is open to prevent negative pressure and to allow elevation for purpose of decompression.

Sterile hot water (110-115°F); sterile kidney basins; glass connecting-tube kept sterile or replaced by a sterile one; a good rubber bulb syringe of the B/D type (and I mean a rubber bulb with a little life in it for suction); and a wide-bore, powerful suction syringe of the Toomey type to break up and evacuate clots.

These are musts to evacuate the bladder and re-establish our closed system.

A word about irrigating media. Cold or cool solution causes shock to the bladder with resultant irritability and vesical spasm. For post-operative prostatectomies, hot water (110-115°F), as hot as one can stand one's hand in, is best. It is hemostatic for venous and capillary bleeding and does not irritate the bladder, unless too hot. Use in the intermittent or continuous flow sys-

tems. How to keep the water heated is a real problem. It can be readily heated up for use in the intermittent systems, but with the continuous irrigation it is a more difficult problem. An electric light bulb, enclosed in a sterile beaker, set in or suspended into the centre of the irrigator, is used in some places. Usually as the water becomes less warm the bladder gradually becomes accustomed to it. It can be reheated by adding hot water to it at intervals. Attempts should be made to keep it as near the optimum temperature as possible. The type of fluid is not important as long as there is plenty of it; 1/10,000 solution of silver nitrate, normal saline and ordinary hot water can all be used. Sterile hot water is as good as any solution and more convenient.



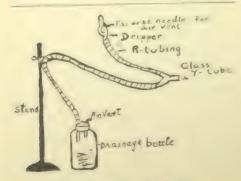
Closed system for tidal irrigation — automatic control (after Cane & Bridges, M.N.I.). Rate of flow: 50-60 drops per minute.

In a pinch, water from the hot water taps can be safely used as it has all

been through the boilers.

The first two to four hours postoperative are the most important from the irrigation standpoint. A good, rapid flow of hot solution should be maintained (use a steady stream). Later, when the bleeding appears to be less, the rate can be decreased to 80-120 drops per minute with intermittent rapid flow flushing of the catheter and bladder to be done q. ½ h., q. 1 h., q. 2 h., 5-6 times per day while *in situ*.

If the amount of bleeding does not become less or even appears to increase the urologic surgeon should be notified, as sometimes it is neces-



Conversion to tidal irrigator

sary to return these patients to the operating-room for evacuation of the bladder, fulgurate for hemostasis, and reset the catheter for our drainage system. This should be done before the patient has become almost "bled-out."

Post-operative pulmonary complications are to be guarded against, particularly chilling during transport to and from the operating-room. A warm bed must be ready on return. Flat position in bed, one pillow under the head, with frequent changes of position is preferred post-operatively. Deep breathing exercises every hour are beneficial. We use deep breathing with the carbon dioxide and oxygen bag for five minutes of each hour for the immediate post-operative period up to 8-10-24 hours.

Sedation must be used as required, especially for the prostatic patients, but one must avoid depressing the

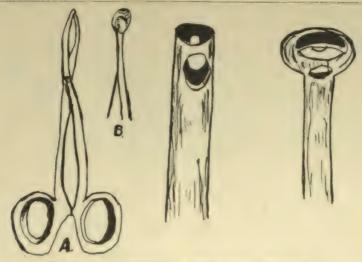
respiratory centre.

High fluid intake is of the utmost importance — by mouth or intravenously. Glucose 5%, in distilled water, is safer to use in forcing fluids intravenously for these patients, provided the blood chlorides are within normal limits and no acidosis is present. This state is evidenced by a decreased carbon dioxide combining power, in which case we use glucose, saline, and/or 1/6 molar lactate solution. Amigen is used in smaller quantities daily in the old patients.

Even small blood loss is poorly tolerated by elderly persons and blood transfusion may be given to replace plasma proteins, replace blood loss, decrease chance of infection and generally to shorten the convalescence.

Old people are especially susceptible to suggestion. Adverse comments should be carefully avoided and encouragement given at every opportunity. The stay in bed is shortened to a minimum. While the patient is confined to bed it is important to change position often and to move the legs about. Where convalescence is long drawn out and progress slow, marked improvement often follows a complete change of surroundings.

Frequent changing of damp or wet

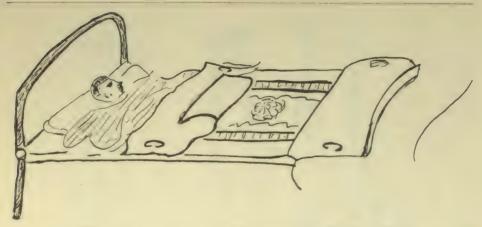


Two views of clot forceps - Freyer tube - Pezzar tube.

dressings and sheets is necessary for the comfort of the patient, as well as for the atmosphere of the ward or room. This is especially important to prevent the chilling of the patient, thus rendering him more liable to complications and causing soggy skin. Routine skin care in these patients assumes more importance when one realizes that the skin covering these tired old backs is prone to break down even under the best of conditions and the likelihood is markedly increased if the patient is allowed to linger on wet sheets and dressings.

Most of our suprapubic prostatectomies are done in one operation. Bleeding is controlled by Foley catheter F. 24, 75 cc. bag perurethra, and an open-end Pezzar tube (catheter) in the bladder suprapubically as a safety valve. This system utilized the drainage and the irrigation systems already described and as used in the perurethral and perineal prostatectomy cases. There are exceptions and occasionally the patient may return to the ward with a Frever tube in the bladder with open drainage on the dressings (or a Marion tube). Frequent evacuation of clots through the Freyer tube by means of sterile clot forceps (small sponge or ovum forceps) is done to ensure an empty bladder to control bleeding. Here,

frequent changes of the dressings and sheets is of paramount importance. This calls for a bed-draping arrangement in which the patient is not disturbed or exposed unnecessarily and yet ready access is provided to the operative site. The upper drape consists of a warm, flannel nightingale worn over the gown, to which a dressing towel is fastened with This drape remains in safety-pins. position between dressings. lower drape consists of a flannelette sheet folded lengthwise and placed under the upper bed-clothing. A dressing towel is pinned to the upper edge. When the dressing is finished. the bed-clothing is drawn up over the patient. A bedside tray is arranged with sterile clot forceps in a jar of sterile water, sterile dressings in covered bowl, sterile kidney basin. sterile scissors and forceps. prostatic patients, whether packing or catheter is used to control bleeding, will, for the first 24-36 hours. complain of a desire to void or move the bowels. After careful check to see that all apparatus is in order. explain the situation to the patient and relieve the symptoms with sedatives. If this urge continues, the patient strains to void or to move the bowels. This stirs up fresh hemorrhage leading to vesical spasm with



Drape arrangement for suprapubic prostatectomy with Freyer tube.

increased bleeding — a vicious circle.

The use of enemata too soon after a prostatectomy may encourage hemorrhage. Most patients have had a thorough cleansing pre-operatively and bowel elimination can be safely resumed on the third or fourth postoperative day with use of divided doses of a mild cathartic such as milk of magnesia, mineral oil, or magnolax. If no bowel movement results then an enema may be given. In perineal cases no enema is given for 5-7 days. Many urologists use a low-residue diet in all prostatectomy cases so that there is less need for bowel elimination post-operatively. When enemata are given, use a soft rectal tube or, better, a urethral catheter to avoid injury to the rectal wall adjacent to the prostatic bed. Belladonna and opium suppositories for pain and the use of a urethral catheter per rectum for gas, if carefully inserted, may be permissible at times.

Abdominal distention is treated with hot abdominal stupes or heat cradle, prostigmine per hypo. In serious cases the Miller-Abbott tube, plus Wangensteen suction, may have to be used.

Nausea and vomiting or hiccoughs are frequently due to the decrease in kidney function which must be attacked with intravenous fluids. Dilatation of the stomach can be ruled out or treated by Wangensteen

suction drainage through Levine or Miller-Abbott tube. The use of the carbon dioxide and oxygen bag provides best treatment for hiccoughs not due to poor kidney function.

Kidney and ureteral surgery: There is less likelihood of post-operative abdominal distention if cathartics are given 36-48 hours pre-operatively, followed by a cleansing enema. Fluid intake should be forced for several days prior to the operation for all urologic patients. Prostigmine 1 cc. hypodermically q. 4 h., started 12-24 hours before and continued 48-72 hours post-operatively, gives excellent results.

Unless the patient has nephrostomy or ureterostomy tube *in situ*, he should lie on the side of operation. He may lie on his back, with icebag under C.V. angle of operated side. This last position embarrasses neither side of chest.

Record fluid intake and output (where possible) on all urologic patients: Fluids may be given freely by mouth immediately on return; enemata as necessary for gas pains. Adequate sedation is required for 24-48 hours post-operatively, after which the wound rapidly becomes less sore, especially if patient moves around.

Post-nephropexy: The foot of the bed is elevated for 14-21 days. The patient may lie on the side of operation, on the back or on the abdomen, but not on the unoperated side.

Nephrostomy and ureterostomy tubes must be handled as already described for sterile closed system of irrigation but with small amounts of fluid used with each increment. The normal capacity of the renal pelvis is 7-12 cc. Special care must be taken to avoid any drag or pull on these tubes as it is very painful to the patient and the tubes may be pulled out of position. Should this occur, the tubes cannot be re-inserted. consequently they must be removed. Too early removal or other accident to these tubes can mean the difference between success or failure of the operative procedure; between a good kidney or the loss of a kidney.

Cystoscopy and retrograde pyelography: This is the backbone of our diagnostic procedures. A sterile specimen of urine is required on all patients and should be collected in sterile containers and examined while fresh. In the male, 2-glass urinalysis is usually done. In the female patient, a catheter specimen is necessary to avoid contamination of the specimen by vaginal secretions. Many urologists insist on hospitalization for a period of twenty-four hours following post-retrograde pyelography even when done under local anesthesia. Observation and care during that period certainly will diminish the chance of suppression of urine, rise in temperature, or discomfort due to instrumentation. The veru and trigone are very sensitive and irritation causes frequency and burning which can be very acute in some patients. Catheterization of ureters can cause irritability of the ureteral mucosa with attacks of colic. This is thought to be due to the mercuric compounds used in sterilization reacting with the iodides of the opaque medium, precipitating mercuric iodide which causes the post-cystoscopic colic. To avoid these complications as well as to treat them, a good fluid intake is required both before and after. In addition, rest in bed, hot sitz baths or hot rectal irrigations, and belladonna and opium suppositories will assist in avoiding troublesome symptoms.

Urinary analgesics as Pyridium and Tr. Hyoscyamus are valuable in treatment. Patients admitted with colic require frequent sedation, forced fluids, and the sieving of all urine for calculi or crystals. Local heat is often valuable in relief of pain.

Acute urinary infections: The usual treatment includes bed rest lying flat, forced fluids, sedation as needed, local heat to relieve painful symptoms, and

sulfonamides as ordered.

Neurogenic bladders: These are difficult subjects to handle. Urologic care is aimed at:

- 1. Keeping urinary tract infection at a minimum. Renal insufficiency is one of the common causes of death.
- 2. Keeping bladder volume or content within normal limits. Back pressure changes in the mid and upper urinary tracts follow prolonged distension or residual urine.
- 3. Every effort must be made to recognize automatic phase which permits removal of catheter and drainage tubes and allows intermittent voiding. Morale is raised, ambulatory existence is made easier and progress better when more normal bladder function resumed.

The use of F. 16, 18 and 20, 5 cc. Foley-type urethral catheters for urethral drainage ensures less danger of complications. Change the catheter every 7-14 days. Cleanse a closed system once a week. Use tidal drainage irrigation whenever possible. Periodic urinalysis, culture and xrays for stones, and a study of the function and appearance of urinary tract help in the diagnosis. Transurethral prostatic resection of the contraction of the vesical neck and bar formation may be necessary to re-establish the optimum bladder function. A Cunningham clamp and a rubber urinal provided for each patient instils confidence. All these cases must be individualized.

No claim to originality is made for this article. It is a composite of the writer's experience at Shaughnessy Hospital; as resident in Froigy, with 1h, Linerson South and associates at the Royal Victoria Hospital, Montreal; and from observations made in prological lines in this country and the

United States. I am especially indebted to Dr. Clyde L. Deming, Yale University, New Haven; Dr. George C. Prather, Boston; Dr. Frederick C. McLellan, New York; Dr. Reed M. Nesbit, University of Michigan, Ann Arbor; Dr. Elmer Belt, Los Angeles; the late Dr. Oscar Mercier and associates at the Hotel-Dieu, Montreal; and Dr. Robin Pearse and associates of the Toronto General Hospital.

Prostatism

EVELYN MYERS

To understand this condition we must first have the necessary knowledge of the anatomy and physiology of the prostate gland. The prostate is a male sex gland resembling a horse chestnut in shape and size. It is located in the neck of the bladder and extends into the posterior ure-It is this situation which makes it become an obstructive entity when it enlarges. In the male embryo, the prostate develops in five lobes: one anterior, two lateral, one middle, and a posterior lobe. The embryonic anterior lobe in front of the urethra atrophies until, in adult life, it is little more than a band of tissue. The two lateral lobes are situated on either side of the urethra, and the middle lobe forms a wedge-shaped portion between them. The posterior lobe is situated below the middle lobe in close relationship with the rectum. The function of the prostate is to produce a thin opalescent fluid which serves to prolong the life of the spermatozoa.

Enlargement of the prostate is a disease of later life, occurring most frequently between the ages of fifty and seventy. The enlargement may occur in any one or in all lobes of the prostate, but usually occurs in the median or lateral lobe. Prostatic hypertrophy falls mainly into two groups: (1) benign hypertrophy; (2)

malignant hypertrophy.

The complaints of the patient all arise from the enlarged gland interfering with the passing of urine: e.g., frequency, nocturia, alterations in the act of micturition such as hesitancy, urgency, difficulty in starting and stopping the stream, and diminution of the stream. There may be burning

on micturition, pain in the lower back, and in the backs of the legs, hematuria, or the obstruction may be complete giving the patient acute retention of urine.

If the patient is allowed to continue with these symptoms, and does not receive a thorough urological investigation and indicated treatment, complications will develop. First, there will be a marked hypertrophy of the bladder wall due to the greater force necessary to empty the bladder past the obstruction. This has the effect of increasing obstruction at the point of outlet of the ureters into the bladder, thus rendering difficult the function of the renal pelvis and ureters in expelling urine into the bladder. This, accompanied by the increasing failure of the bladder to empty itself, results in back pressure upon the kidnev with dilatation of the ureters and of the kidney pelvis (hydronephrosis). Owing to this dilatation, there will be compression of the renal parenchyma and atrophy, with the resultant loss of ability to secrete toxic endproducts of metabolism. being retained, will cause the patient to pass into a semi-uremic or uremic state. This condition is called uremia and is recognized by: (1) dry tongue; (2) dry skin; (3) emaciation; (4) anorexia; (5) lethargy.

If, when the patient is admitted to hospital, his complaints are in keeping with those already mentioned, a routine investigation is carried out:

(1) A urinalysis is done. (2) Rectal examination will reveal enlargement of the lateral and posterior lobes. (3) He is catheterized for residual urine, and, if excessive, a decompression apparatus may be set up to provide

temporary drainage, and to improve the bladder tone. (4) Blood is taken for the determination of the non-protein nitrogen and urea nitrogen. (5) Unless contra-indicated, a cystoscopic examination is carried out, in which the exact state of the bladder and the prostate is observed. The ability of the kidneys to secrete is tested by intravenous injections of indigo-carmine, and retrograde pyelograms are taken of the kidney, pelvis, and ureters if necessary. Intravenous pyelograms are also very valuable in studying the form and position of the kidneys and ureters, and to determine the function of the kidneys.

These examinations indicate the operation to be carried out in any type of "benign hypertrophy." The prostate may be removed by a variety of methods: (1) suprapubic prostatectomy; (2) retropubic prostatectomy; (3) perineal prostatectomy; (4) transurethral resection of

the prostate.

SUPRAPUBIC PROSTATECTOMY

This is usually a "two-stage" operation, and is undertaken in patients in whom prolonged drainage is required on account of extensive damage to kidney function, or on patients for whom drainage by catheter is unsatisfactory.

The first stage consists of opening the bladder, and inserting a mushroom catheter, about which the bladder and the wound are then closed. This drainage is continued until the general condition of the patient is entirely satisfactory. Sometimes the patient is allowed to leave the hospital and continue with his suprapubic drainage for some months, and then return for the second stage. In ordinary cases, the second stage follows the first stage in ten to fourteen days.

Nursing care: The nurse should get the drainage equipment ready for use while the patient is in the operating-room. It consists of drainage bottle, rubber tubing, glass connecter, sterile irrigating solution, and bulb syringe. When the patient returns to the ward, the suprapubic catheter is immediately connected to the drainage bottle, and irrigated every hour or more often according to the amount of bleeding. The head of the bed should be elevated as soon

as possible. Fluids should be forced as soon as they can be tolerated, and an accurate fluid intake and urinary output record charted. Traction on the catheter is prevented by fastening the drainage tubing to the bed with a safety-pin. By fastening the abdominal binder on the same side as the drainage tube, there will be free drainage of urine from the catheter.

The dressings are changed twice daily, or more often if required. The incision is cleansed with alcohol and painted with mercurochrome solution. The cigarette drain is usually removed at the end of twenty-four hours, the clips are removed on the fifth day, and the retention sutures are removed on the tenth day.

A scrotal support is a very valuable aid in preventing epididymitis. A vasectomy, however, is usually performed during the first stage of the operation to prevent this inflammation.

For the second stage of the operation, the patient is prepared in the usual manner for the operating-room, the suprapubic catheter being clamped off. This operation consists of the enlargement of the opening through which the suprapubic catheter has passed, and the enucleation of the gland through this wound. The bleeding is controlled by the introduction of a Pilcher's Bag, and pressure is applied by filling the bag with sterile water. Tension is applied by the use of the "wire cage," supported under the scrotum.

As soon as the patient returns to the ward, the nurse should be on the alert for complications, the first and most dangerous being shock. Because of advanced age, operative trauma, and loss of blood, prostatic patients will go into shock very quickly. The treatment is the same as for all surgical shock. Hemorrhage is another dangerous complication. Traction on the tube coming through the urethra will probably check the bleeding.

Four hours after the patient returns to the ward, the tension is somewhat released by removing the wire cage. We must watch very closely now for

Eight hours following hemorrhage. the operation, the water is released from the Pilcher's Bag by cutting the silk from the tube. Dressings must be changed frequently, as the urine drains into them. Fluids are forced, and the fluid intake and urinary output must be accurately recorded. four hours after the operation, the Pilcher's Bag is removed by the in-The nurse must have a tray ready for him, consisting of hydrogen peroxide, sterile dressing forceps, and emesis basin. Again, we must watch carefully for hemorrhage. Now the time has arrived for the setting up of the "electric pump," a suction apparatus used in siphoning the urine from the bladder through the suprapubic wound into a drainage bottle. This is left in place until the wound begins to close, and the patient starts to void. Ordinarily, he should be ready to leave the hospital within two weeks following this operation.

RETROPUBIC PROSTATECTOMY

This is a one-stage operation in which the prostate is removed through an incision made through the prostatic capsule below the bladder area. Unlike the suprapubic prostatectomy the bladder in not opened. A two-way irrigating Foley catheter (75 cc. balloon capacity) is usually inserted in the bladder ber urethram.

On return to the ward, a continuous bladder irrigation is set up, consisting of a Kelly bottle, rubber tubing, Murphy drip, glass connecter, and drainage bottle, and using the solution as ordered by the urologist. This is usually continued for ten days, the catheter then being removed (by first removing the water from the balloon). The incision is cared for as in the suprapubic prostatectomy. Special attention should be given to the forcing of fluids, and an accurate record of the fluid intake and the urinary output recorded.

These patients are generally allowed out of bed early, before the catheter is removed. Before leaving the hospital urethral dilatation is carried out by the "passing of sounds." The hospitalization period is two to three weeks.

TRANSURETHRAL RESECTION

In this operation, the obstructive tissue of the prostate gland is removed by means of electrically-lighted instruments introduced and operated through the urethra. Spinal anesthesia is the most common choice of anesthetic used.

The patient returns to the ward with a Foley catheter inserted into the bladder through the urethra; this catheter is immediately connected to a drainage bottle. It is the responsibility of the nurse to see that the catheter is irrigated and free drainage allowed at all times. order to maintain free drainage, the catheter must be irrigated every fifteen minutes, or more often if the bleeding is 'excessive. The choice of irrigation solution rests with the The irrigation may be surgeon. carried out by the use of a bulb syringe, or by the method more commonly used today, consisting of a Kelly bottle, Murphy drip, Y-glass connecter, rubber tubing, and two shut-off clamps. In this latter method, by clamping off the tube leading to the drainage bottle, and allowing 50 cc. of irrigating solution to enter the bladder, and remain there for fifteen minutes, very good results have been obtained. If sufficient time is spent on the patient's return to the ward in irrigating the catheter continuously until the return flow becomes quite clear there is much less danger of clot formation. On the second day, if there is very little bleeding, irrigations at half-hour intervals should be satisfactory. The catheter is removed on the morning of the third day if there is no bleeding.

The forcing of fluids is very important, also the record of fluid intake and urinary output should be charted. The patient's head should be elevated as soon as the effects of the anesthetic have worn off, and he should be encouraged to turn freely from side to side. These patients, being elderly, are particularly susceptible to congestion of the lungs. If no complications occur, they are generally allowed up on the fourth or fifth day. The amount of residual

urine is tested on the eighth day and, if excessive, sounds are passed on the tenth day. The patients are usually ready for discharge from hospital on the thirteenth day.

PERINEAL PROSTATECTOMY

This type of operation is performed less frequently but, by this method, the prostatic gland is removed through an incision made in the perineum.

The patient usually returns to the ward with a urethral catheter draining the bladder. Unlike the previous operations, the catheter should not be irrigated as freely, but only enough to keep it open because of the danger of the fluid leaking through the perineal incision. The catheter usually remains in the bladder until the perineal wound is completely healed.

MALIGNANT HYPERTROPHY

This is determined by rectal examination which will show the prostate to be very hard and fixed with a moderate degree of enlargement; or biopsy which will show the infiltrating carcinomatous tissue. In this disease there is a tendency to metastasize to the bones, chiefly those of the pelvis, sacrum, and dorsal spine. Therefore, an x-ray is always taken of these areas. Blood is also taken for acid and alkaline phosphatase tests, which are usually elevated in this disease par-

ticularly when metastases occur. Hence, on this basis, the diagnosis is made.

Unfortunately, this is not a field in which surgery can offer any considerable chance of cure. The obstructing portions of the growth are removed by means of transurethral resection. A bilateral orchidectomy is performed, which is often very valuable in relieving the severe pain of bone metastases. The operation may be followed by x-ray therapy. and the administration of stilbesterol. This treatment offers relief of symptoms for a time. It is surprising how long many of these patients will carry on with a prostatic carcinoma. Malignancy in this area is often much slower in producing a fatal termination in other tissues of the body.

SUMMARY

1. In any bladder operation, it is extremely important to keep the catheters free from occluding blood clots.

2. It is extremely important to keep any patient bordering on a uremic state, or with decreased urinary output, on a high fluid intake.

3. These patients, being elderly and showing some senile mental changes, need very close observation and a great deal of cheering in order to see that they are making satisfactory progress, and that they are imbued with the desire for recovery.

Manitoba University School

Nurses throughout Canada will be glad to learn of the decision of the Board of Governors of the University of Manitoba to continue the School of Nursing Education. This western school is greatly needed as it supplies public health nurses, teachers, and supervisors for a large section of the prairies. Public interest has been tangibly expressed by the provision of several worthwhile scholarships. Information concerning these scholarships may be obtained from the Director of Nursing Education, University of Manitoba, Winnipeg, or from the Executive Secretary, Manitoba Association of Registered Nurses, 214 Balmoral St., Winnipeg.

Preview

The nurse who has lived all her life among the niceties of a town or city home has very little conception of the rugged existence of some of our fellow countrymen who choose to live in the more remote areas of our vast land. Yet those people are as much in need of nursing care and health teaching as the families in our midst. The Canadian Red Cross Society has long recognized this need and has provided care through the outpost nursing services. One of their staff, Muriel I. Schonberg, gives you some of the plain facts in her gripping article which will be published on the Public Health Nursing Page next month.

New Methods of Treatment for Venereal Disease — Gonorrhea

B. D. B. LAYTON, M.D.

A CONSIDERATION of recent advances in treatment methods for gon-orrhea in both male and female brings to light a succession of most interesting developments. One has only to look back over the past several years to appreciate what remarkable progress has been made in this field and, with the promise of what present treatment procedures appear to hold, confidently be reassured that the future of gonorrhea therapy is highly optimistic.

To comprehend the full significance of the progress made, a brief glance into the past provides a rather striking comparison with modern methods. In both male and female gonorrhea, in earlier days, the accent was on local treatment. Instillations and irrigations in the male urethra with various chemicals and multiple prescriptions incorporating urinary antiseptics and sedatives formed the basis of the medical

In the female, douches employing various types of antiseptic solutions, topical applications of strong chemicals, medicated tampons, urethral injections, and local heat applications by hip and sitz baths, or by somewhat complicated intravaginal contrivances, all have found varying degrees of popularity at one time or another.

treatment.

In reviewing these earlier methods one does not, by any means, hold them in ridicule. To the contrary under certain circumstances and in certain complications the employment of effective local measures is a valuable adjunct. In the main, however, the treatment of gonorrhea in both male and female has resolved itself into the logical conclusion that any procedure which will support the natural recuperative processes of the body, both local and general,

without further injuring the affected tissues or interfering with free drainage of infected secretions, should be considered of value. Conversely, any agent such as a strong chemical or instrumental interference with acutely influenced structures is, in the opinion of most thoughtful urologists and gynecologists, to be rigidly avoided.

It is interesting to note that the general measures recommended in the past are quite consistent with accepted modern procedures. Even under our most advanced methods of treatment, increased rest is considered beneficial regardless of the stage of the disease. In the female, especially, bed rest is most helpful. General supportive nursing procedures contribute much to recovery, particularly if complications ensue. To mention briefly the diet — the patient is advised to partake of a soft, easily digestible diet while greatly increasing the intake of fluids and rigidly avoiding condiments and highly seasoned foods. Abstinence from all types of alcoholic drinks is imperative and the patient should be warned that all forms of sexual excitement are likely to be harmful.

THE SULFONAMIDES

With this brief consideration of past practices and continuing general measures, one turns to review the first of what might be described as the two major steps forward in gonorrhea treatment — the sulfonamide era. Commencing with the introduction of sulfanilamide, and followed by the rapid development of similar compounds of this group, a wave of enthusiasm and optimism was stimulated. There was great promise that at last this obstinate infection was to be brought under proper therapeutic control. We know now

that such was, unfortunately, not entirely the case and that the original promise offered by the sulfonamides

has not been wholly fulfilled.

Four sulfonamide compounds have been employed in the treatment of gonorrhea: sulfanilamide, sulfapyridine, sulfathiazole, and sulfadiazine, their development occurring in that order. The relative effectiveness of these drugs now appears to be fairly well determined and the consensus rates their therapeutic efficiency in reverse order of their development. This view is supported by the results of a large number of clinical studies which have been successfully concluded. In considering the employment of sulfonamide compounds for the treatment of gonorrhea, sulfadiazine and sulfathiazole are the drugs of choice, the latter being only slightly less effective. Both give better results and are better tolerated than are sulfanilamide or sulfapyridine. must be remembered, however, that all sulfonamides carry the risk of toxic phenomena.

As a further observation, resulting from wide clinical experience with the chemotherapy of gonorrhea, it is recommended that cultures of the gonococcus be employed for diagnosis and the determination of cure, wherever possible, in preference to smear examinations. It has also been determined that in the female a condition when only apparently cured is most likely to recur following the menstrual period. Obviously then in the determination of cure the likelihood of dependable smear and culture examinations is greatest when such tests are made immediately following the cessation of the menses.

Another interesting feature was brought out in a study dealing with the investigation and treatment of a large group of proven or suspected prostitutes infected with chronic gonorrhea. It was found upon a amination of 615 women, all culturally positive, that only 20 per cent were noted as having clinical evidence of gonorrhea at the time of the initial examination. Repeated examinations, however, revealed a greater percent-

age to have clinical signs of the disease. This finding in itself serves to emphasize a most important aspect of venereal disease control, i.e., the clinical examination of the suspected individual without supportive laboratory evidence is highly unreliable and cursory examination of individuals, such as prostitutes and promiscuous amateurs, is of little value in detecting evidence of the disease.

In recent years there have been increasing indications that there are certain strains of gonococci which do not respond to the effect of the sulfonamides, the so-called sulfa-resistant organisms. It has been noted, particularly if treatment is not carefully carried out with adequate dosage, that gonococci tend to become resistant to the curative effect of the drugs to such a degree that considerable difficulty may be encountered in using these compounds effectively.

By way of explanation, it has been suggested that the administration of inadequate doses of sulfonamides, while not only failing to destroy the gonococcus, have also had the doubly unfortunate effect of building up its resistance to the Thus, at a later date when doses are administered which originally would have been adequate, not only do they fail to destroy the germ but also further stimulate its increased resistance. As evidence of this situation accumulated, it became apparent that other means of attacking these sulfonamide-resistant organisms had to be developed to prevent their widespread dissemination. One of these procedures is described as the fever treatment, or hyperpyrexia.

FINER THERAPY

The treatment of gonorrhea by elevation of the body temperature to levels comparable with high fevers probably resulted from the observation that during prolonged febrile reactions due to other conditions, such as pneumonia, typhoid fever, etc., gonorrheal discharges became reduced or completely disappeared. This

mentation, primarily to determine the level and duration of fever necessary to accomplish this result and, secondly, to evolve a satisfactory method of providing such a fever.

Regarding the first factor, there was at first a remarkable diversity of opinion on the desired level. After a great deal of experimental study, however, it was determined with a fair degree of certainty that at 106.7°F. the great majority of strains of the gonococcus are killed in from five to fifteen hours. One group of investigators studied 130 different strains of the germ and found that they all succumb at this temperature.

Many methods were devised to elevate the temperature. In Germany, in 1912, prolonged immersion in hot water was tried but, as Pelouze points out, "beyond killing a number of people who otherwise might have lived many years this procedure got nowhere." Malaria inoculations were attempted with some success but because the malaria was harder to bear and was more dangerous than the gonorrhea it has been largely abandoned.

The search for other methods of raising and regulating body temperatures resulted in the development of several different varieties of fever cabinets, the most widely known and studied probably being the Kettering Hypertherm. By this device, body temperature can be raised to the desired level and maintained there for a prolonged period. Of the many different treatment programs described most follow the pattern of raising the body temperature to 106° to 107.2° F. for a period lasting from five to ten hours and repeating every few days as required. The number of such treatments may range from two to twelve or more.

That this procedure is rigorous is quite obvious. To quote Pelouze in reference to hyperpyrexial treatment: "It is an ordeal in which many patients go dangerously close to the pearly gates, some hear the hinges creak and some just stop hearing forever."

In summing up the status of fever

treatment the recommendation of Carpenter and Warren seems to express the popular opinion best: "The method should be reserved for the treatment of the graver complications of gonorrhea and those patients who have resisted cure by other less dangerous and trying therapeutic measures."

PENICILLIN

Prior to the development of penicillin, hyperpyrexia was used chiefly for the treatment of cases of gonorrhea resistant to sulfonamides and other forms of treatment. However, since penicillin has shown such remarkable, effective results in these cases the hypertherm has generally fallen into disuse.

The second major advance in the progress of modern gonorrhea therapy consisted of the discovery and clinical application of the most famous of all the so-called miracle drugs — penicillin.

While still exhibiting several uncertain features, the penicillin treatment of gonorrhea has now established itself as a highly effective, rapid, and non-toxic procedure. The dosage level of the drug appears to have become fairly well fixed and the major consideration remaining at the moment concerns the best schedule for its administration.

These conclusions have not been reached as rapidly and as easily as one might suspect. The scope of the clinical research carried out is rather staggering and thus is difficult to condense in a brief review. It should, however, be interesting to touch upon the general features of the major developments, as they have occurred, up to the stage of the most recently published observations on this drug.

In the initial studies conducted, the tendency was toward the administration of total doses considerably smaller than the quantities which now appear to be adequate. The results were, on the whole, quite satisfactory, but since higher cure rates were achieved by increasing the total quantity of the penicillin, other schedules of treatment were

investigated in which progressively larger amounts were administered. This led to the determination of what is now accepted as the adequate

dosage level.

To illustrate the progress of these studies during the past few years the following reports are selected more or less at random. In a group of 450 patients treated in the U.S. Army, treatment was administered according to three schedules. In the first, 105 patients were treated with a total of 160,000 units of penicillin with a 2 per cent failure rate. In the second group of 112 patients, to whom 100,000 units were administered, the failure rate was 9.8 per cent. In the third group, 233 patients were treated with a total of 50,000 units and 23.6 per cent of these failed under treatment. Of those treatment failures on the three schedules further treatment with larger doses was successful.

In 360 male patients suffering with sulfonamide-resistant gonorrhea, another investigator reported the results of nine treatment schedules, including total doses from 35,000 to 160,000 units of penicillin extending over periods from six to forty-five hours. The over-all cure rate was 88.8 per cent and re-treatment of the thirty-four failures with 100,000 units cured all but three who were later cured by a third course of 160,000 units.

Employing a total dosage of 200,000 units, Heller has recently reported that in 398 patients, white and negro, male and female, from 94 to 96 per cent of the cases were cured.

As a result of this and other published studies in which a similar amount of the drug has been administered, it becomes increasingly apparent that the adequate treatment of gonorrhea with penicillin in aqueous solution now appears to require a total dosage of 200,000 units or more. While the results of certain investigations, in which slightly smaller doses were employed, present a higher percentage of cures, in considering the overall picture and the importance of permanently eradicating the infect-

ing organisms, the administration of the larger dosage of penicillin is recommended.

The next significant step to be taken in the progress of penicillin therapy was aimed at prolonging the effect of a single large dose of the drug, i.e., a one-injection treat-To determine a satisfactory delaying medium, Romansky investigated the effectiveness of suspensions of penicillin with a variety of substances, such as refined peanut oil, sesame oil, cotton-seed oil, corn oil, castor oil, olive oil and protamine Although each of these was found to exert a noticeable delaying effect they were not considered entirely satisfactory and further study was necessary before the combination of penicillin with peanut oil and beeswax (POB) was elaborated and adopted as a satisfactory medium.

Employing this mixture clinically, Romansky reported on a series of 175 cases of gonorrhea in males treated with single injections of penicillin in peanut oil and beeswax suspension. Seventy-five patients received a single injection of 150,000 units and no failures were encountered. One hundred patients received 100,000 units in one injection with a cure rate of 93 per cent. The seven failures responded to a second single injection of 150,000 units of penicillin. This mixture has produced no abnormal reactions either locally or con-

stitutionally.

The original work by Romansky has been confirmed by a number of investigators. Van Slyke and Heller reported the results of the study of 1,060 patients, each of whom received a single intramuscular injection of 200,000 units of POB. Ninety-two per cent of the cases were classified as cured following the treatment.

Another type of delaying medium which has been studied consists of peanut oil and falba, a lanolin-like substance. The product has a viscid consistency which becomes liquid when warmed. Mixed with penicillin in aqueous solution an emulsion is formed which may be injected with ease.

Studying the clinical effectiveness of this emulsion Cohn found that, following the administration of a single injection of 150,000 units of penicillin in peanut oil and falba, 101 out of 105 patients with gonorrhea were cured. No untoward local or systemic reactions were observed and the patients whose infection failed to respond to the first course were subsequently cured by a second identical course of therapy or by using larger amounts of penicillin than administered initially.

The further search for easy, simplified methods of administering penicillin has resulted in the study of the effectiveness of the drug taken by mouth. While it is known that penicillin is readily destroyed by the gastric juices recent reports point to possible measures which will overcome this obstacle to oral administration, i.e., the use of the so-called buffered preparations which resist the destructive effect of the acid stomach

Juices.

In one study it was found that, in order to obtain an adequate concentration of penicillin in the blood, from three to four times the amount of the drug had to be given by mouth as is ordinarily administered by injection. Later reports appear to be more favorable but at the moment the status of this procedure is still undetermined and thus awaits additional investigation.

OPHTHALMIA NEONATORUM

Turning briefly to the consideration of one of the more pitiful conditions caused by venereal infections, a study of 1,176 individual blind persons in Massachusetts showed that in 128 cases, about 11 per cent of the total, the blindness was due to syphilis. In thirty-two cases, about 2.7 per cent, the blindness was caused by ophthalmia neonatorum resulting from gonococcal infection.

This figure is consistent with other reported and somewhat more general observations attributing 2.4 per cent of all blindness to the condition. Thanks to Credé, who over sixty years

ago systematized and published a method of preventing ophthalmia neonatorum by the simple installation of silver nitrate drops into the eyes of the new-born babies, the condition which once was responsible for 30 per cent of all cases of blindness has been reduced to its present level.

It cannot be said, by any means, that all danger from this disease has been eliminated. Unfortunately Credé's prophylaxis and prompt treatment of cases does not strike at the root of the evil. For example, it has been found that in spite of the routine instillation of silver nitrate into infants' eyes at birth, the New York City Health Department reported 213 cases occurring between 1938 and 1942. To be absolutely safe from the blinding danger of the gonococcus, gonorrhea itself must be eradicated.

With earlier therapeutic measures the disease was prolonged, the treatment exhausting and conplications frequent, often resulting in blindness. Fortunately, sulfonamide therapy was found exceedingly beneficial in this condition. As an example, in one study employing sulfathiazole orally, all babies tolerated the drug well, the duration of symptoms and positive smears was only one to four days. and the duration of illness in the total group ranged between one and fortysix days. All infants were observed in the hospital approximately one week after cure and there were no complications or relapses during the follow-up period.

It is apparent that with the advent of the sulfa drugs the treatment of ophthalmia neonatorum was greatly improved. The administration of these drugs and the installation of sulfa ointment did much to shorten and simplify the treatment. However, the discovery of penicillin has revolutionized the treatment of this disease and, where the sulfonamides cleared the condition within days, penicillin clears it within hours.

It should be stated that penicillin therapy of gonorrheal ophthalmia is not yet sufficiently well standardized for any explicit suggestions to be given for its general use. Ex-

perience to date, however, is exceed-

ingly optimistic.

Two points are essential in the treatment of ophthalmia with penicillin; adequate concentration of the drug and frequency of application. According to the experience encountered in an institution in England the most consistent results are obtained when a solution of 2,500 units per cubic centimetre is used. With regard to frequency of treatment, progressive improvement in results was noted when the interval between the instillations was reduced from one hour to one-half hour and still further to five minutes. In the most recently treated cases the penicillin solution has been instilled at intervals of one minute and generally speaking all pus can be suppressed within thirty min-Thereafter a simple conjunctivitis, giving no anxiety, is left which heals within two or three days.

Despite these remarkable results the fact remains that in this, as in all other diseases, prevention is better than cure and the careful application of prophylactic measures and suitable nursing techniques will best reduce the hazards presented.

DUAL INFECTIONS

Numerous workers, carrying on intensive studies of the treatment of venereal disease with penicillin, have brought to light a most interesting observation. It is obvious that in acquiring gonorrhea any individual may have simultaneously contracted syphilis. Both diseases respond to penicillin. In treating the gonorrhea, which would probably be the first to develop clinically because of its shorter incubation period, in some instances it has been observed that the total dosage of penicillin required may be sufficient to delay or abolish completely the appearance of the early signs of syphilis without checking its further progress. Treatment for gonorrhea may, therefore, mask developing signs and symptoms of syphilis, leaving the patient with a false sense of security —an unwitting victim of the spirochete.

There are no data from which it may be learned how often dual infections of gonorrhea and syphilis are acquired from one or more exposures within a short time, but as an important finding in the control of syphilis it has been noted that, over a period of one year, 9 per cent of the total admissions to the rapid treatment centres in the U.S.A. consisted of patients infected with both syphilis and gonorrhea. It must, therefore, be stressed that when any case of gonorrhea is treated, there should be a high index of suspicion that syphilis too may be present. This can only be detected by careful physical examination and blood testing.

SUMMARY

In concluding this review one may state, in summary, from the information available it would apppear that the use of penicillin as an effective therapeutic agent for gonorrhea seems well established, and there is general agreement that with the commercial penicillin, as now produced, satisfactory results in the management of gonorrhea may be expected with a total dosage of 200,000 Oxford units or more. The major consideration remaining at the moment concerns the best schedule for administering the drug. Ideally, this would require a minimum of time plus a minimum of special equipment without any sacrifice of therapeutic efficiency. Ideally. too, the most desirable schedule would be one administered on an ambulatory out-patient basis and would combine safety, convenience, and the least possible discomfort for the patient. achievement of these levels of near perfection in gonorrhea treatment may well be realized in the immediate future.

With UNRRA in Germany

LYLE M. CREELMAN

Long before VE-Day (May 8, 1945), which marked the end of the war in Europe, it was recognized that there were many problems of peace which must be dealt with on an international basis, and preferably by an inter-

national organization.

The most urgent of these was the task of caring for the millions of people of many nationalities who had been displaced from their homes by actual war; had fled before the enemy; had been offered the alternative of compulsory work in Germany or starvation; had been the victims of political or religious pressure; or had been part of the huge deliberate transfer of populations that, particularly in Poland and the Baltic States, had been carried out for political reasons. For all these people there was the problem of immediate relief, necessary rehabilitation and, ultimately, repatriation. For some there was no possibility of repatriation, and to the problem of relief and rehabilitation had to be added the possibility of resettlement, temporary or permanent, in some hospitable land.

The United Nations Relief and Rehabilitation Administration—UNRRA. as it soon came to be called - was set up to undertake this gigantic task, and, immediately upon the unconditional surrender of Germany, it was called upon to provide as rapidly as possible spearhead teams, complete units, and later specialized services to aid the army. These were finally to be welded into a semi-independent, co-operative agency. The earliest members were in operation even before the fall of Germany, striving to do whatever could be done among the masses of refugees, displaced persons, and hordes of allied and enemy civilians who literally in millions crowded the roads of western Germany.

There has never been any accurate estimate of the total number of displaced persons at that time in this area, but figures of from six to eleven millions have been quoted, and undoubtedly the truth lies between these — nearer the upper than the lower figure. All had suffered much in mind and body. They had been uprooted from their homes, and did not know if they would ever live to return or, indeed, if there would be a free homeland to which they could return. Many were separated from their families and often ignorant of their fate or only too well aware of it. Most of them were wretchedly ill-clad, hungry and deprived of all sources of regular food.

It was into this massive and somewhat terrifying confusion of people and problems that I was asked by the UNRRA chief medical officer in the British Zone in Germany to accompany him as chief nurse (June 11, 1945). My immediate reaction, when asked to organize the nursing service of UNRRA for the displaced persons operation in the British Zone of Germany, was an eager desire to accept the job, and a great happiness at having some small part in this

tremendous undertaking.

GETTING READY

The inevitable delays associated with the collection of the necessary office staff, equipment and, above all, transport; the many formalities that had to be dealt with in respect of passports, travel orders, and all the essential but irksome red-tape associated with visiting what was still an enemy country under immediate military guard, occupied a month. Finally, all was ready, and the chief medical officer, and I, a secretary, two drivers, and two new cars proceeded from London to Purfleet, boarded an Army LST and set out in convoy to cross the Channelrendered dangerous just then by a heavy storm in the North Sea which had caused thousands of mines to

(Continued on page 552)

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

The Orientation of Nurses

MARGARET M. STREET

A PROGRAM of ward instruction was initiated in the Ross Memorial Pavilion, Royal Victoria Hospital, at the beginning of January, 1946. The program was designed to include both students and general staff nurses.

The Ross Memorial Pavilion has a capacity of 120 private beds. The objective has been to have an allgraduate nursing staff in this building. However, due to the shortage of nurses, it has not been found possible to realize this entirely, and there are always several students on each floor. The floors are segregated, as far as possible. Both general staff and student nurses are on straight eight-hour duty with occasional broken periods of duty in the day-time. They work a six-day week. A ward aide or a nurse's aide on each floor attends to such duties as changing the drinking-water, flowers, dusting. cleaning granite-ware and beds on discharge of patients, running errands, etc. An information clerk on each floor answers the telephones, takes messages to doctors and patients, helps to make out the ward slips, and directs visitors. Thus, the nursing staff can devote most of their time to the actual bedside care of the This factor is favorable patients. to the development of a ward teaching program.

Establishing the Ward Instruction Program

1. The ward instructor submitted

to the superintendent of nurses and to the supervisor of nursing of the Pavilion a plan for the program. This was referred to the instructor in charge of the teaching department. Constructive suggestions received from these sources were incorporated into the plan, which was then ready to be introduced.

2. A meeting was called of the supervisory and head nurse staff of the Pavilion, at which the ward instructor presented the plan for the ward teaching program. The objectives, scope, and proposed methods were outlined, and a copy of the plan given to each head nurse for study and comment. A copy of the plan was given also to the night supervisor for her information.

3. A meeting was called of the general staff nurses of the Pavilion, at which the ward instructor was given an opportunity to explain the manner in which it was expected that a staff education program might be developed.

4. The ward instructor had an individual, informal conference with each of the head nurses regarding the points in nursing care and in ward routines which should be stressed by the instructor in her contacts with both students and general staff nurses.

5. A ward instruction office was established in a convenient location. The office was partially screened off and contained the following:

A desk with locked drawers; chairs of a

JULY, 1947 533

type to be stored easily when not in use; a blackboard and a small bookcase; a locked filing box to hold 5" x 8" cards; a small source box: a reference library consisting of text or reference books and a medical dictionary; a file of literature on trade drugs.

This office is well lighted and is a pleasant, quiet place in which to hold

conferences.

NATURE, SCOPE AND METHODS

The ward instructor carries the dual responsibility of teaching and of assisting with the supervision of the nursing care of patients by the general staff and the student nurses. In both of these respects, she may be considered as rendering assistance to the head nurses, whose primary functions these are, but whose time is so taken up by the many administrative duties that they are not always able to devote as much time as they would wish to detailed supervision and teaching.

The ward instructor is on duty from 7:30 to 4. Monday to Friday inclusive. She has every Saturday off, and alternate Sunday mornings. The mornings are spent either in orienting new nurses or in visiting patients with a view to supervision of nursing care. The afternoons are spent in conferences, planning of work, records, etc.

Before commencing her morning visits to patients, the instructor reads the night report and makes notations regarding the new patients on each floor, pre-operative patients, patients who are slated for tests that day, and seriously-ill patients. She notes also the census of patients on each floor, with special reference to the patient-nurse ratio. Between eight and nine o'clock, on mornings when there are no new nurses, the instructor visits each floor and makes notes regarding the patient-assignment of all students and general staff nurses. She checks the treatment sheets and order books and notes points which she should check. During this initial visit to the floors, the instructor may stop to observe, for example, the work of a student in preparing a patient for the operating-room or for the x-ray de-

partment, or the preparation of a room for the return of a patient from the operating-room. She then commences her visits, and observes the morning care which is being given. Corrections and suggestions of a minor nature are usually made directly to the nurses concerned (outside of the patients' rooms), but more serious matters pertaining to patient care, and all matters pertaining to ward administration are reported to the head nurse. It is necessary for the ward instructor to exercise judgment constantly as to which matters should be referred to the head nurse. In practice, few difficulties have arisen. Students may be given assistance in giving morning care to sick patients—e.g., a cardiac patient in an oxygen tent; or a treatment may be discussed and the preparation for it checked with the student. It has not seemed feasible, for the most part, actually to supervise the giving of a treatment in the private rooms, although this has been done to limited extent, when it seemed in the best interest of the student and of the patient to do so.

The student nurses' program has the following objectives:

1. To assist in the orientation of the student: (a) to the physical plant and equipment of the Pavilion; (b) to the ward routines, and to the care of the private ward patient.

2. To assist in developing an appreciation of the factors contributing to good basic nursing care, and of meticulous workman-

ship in carrying out this care.

3. To assist in strengthening an appreciation of the importance of skilful observation of the patient in order to anticipate his needs, and of keeping before her the "patient point of view."

4. To contribute to the extension of the student's clinical knowledge by encouraging her to carry on independent, directed study by individual or group conferences, and by day-by-day supervision and bedside demonstration or instruction.

FORMAL STUDENT PROGRAM

1. Orientation of new students: (a) Before the student comes to the ward, the instructor procures from the Training School Office a record of her clinical experience. This information is transcribed to a 5" x 8" card, which is to contain the record of the student's conferences and progress. The back of the card is ruled to serve as a record of the ward teaching and supervision. The card is then filed in the "active" section of the locked file.

section of the locked file.

(b) The instructor endeavors to find an opportunity to discuss with the head nurse the clinical background of the student, with special references to points in which she may be expected to need special instruction and supervision—e.g., the student may have had no previous experience in ear, nose and throat nursing, in which case she will have to be supervised closely if assigned to the care of these patients.

(c) On the morning of the student's arrival on the floor, the head nurse explains the treatment and nursing care of the group of patients assigned. Following this, the ward instructor takes charge of the new student, and first explains the routine of the ward factors in pre-breakfast care, in morning care, duties of the student, of the nurse's aide or ward aide, and of the orderly and the maids. She then shows the student the location of the chief service facilities, and takes her into the room of one of the patients assigned to her care. Here, she is introduced to the patient, and the instructor shows her where the patient's equipment is kept. She then proceeds to prepare her patients for breakfast. Inasmuch as the necessary orientation has taken some time (10-15 minutes), the instructor may assist the student, on this first morning, with the pre-breakfast and the regular morning care. After this has been completed in detail, and treatments, if any, recorded, and after any other duties for which she was posted have been performed by the student, the instructor conducts her on a detailed tour of the floor. Following this, usually from 11:00-12:00, an orientation conference is held in the instructor's office. The ward routines are further explained, the basic factors in good nursing care are reviewed, and the essentials in planning the daily care of patients are stressed and illus-

trated. An attempt is made also to encourage the student to define the learning objectives which she has in coming to this Pavilion, and to point out to her the learning opportunities which she will be able to find here. The student is then conducted on a tour of some of the main departments the nursing office, the clerical office, the porters' station, the supply room, the linen room, the x-ray, the physiotherapy and the fever therapy departments. The functions of these departments are outlined, the manner in which they are related to the nursing service, and the ways in which the individual nurse may facilitate the work of each, in the service of the patients, are discussed.

If, as frequently happens, several new students come to the building on the same day, and to different floors, the ward instructor must decide in advance, by a study of the clinical backgrounds, which student or students will probably be most in need of her assistance. She then acquaints the head nurses with her plan of procedure. The head nurses will plan to carry on such orientation as may be essential until the ward instructor is free. There may be three or four students at the initial conference.

The conference schedule (both for students and for graduates) is posted a week in advance, after the instructor has obtained the nurses' hours of duty for the week, as planned by the head nurses. A typed copy of the conference schedule is posted on each floor, with copies going to the superintendent of nurses, the teaching department, and the supervisor of nursing. All conferences are held in the hours on duty, usually just before or after the noon-hour. Not more than one student or one graduate at a time will be scheduled for conference from one floor.

(d) On the second day, the instructor supervises as closely as possible the work of the new student or students, giving such guidance as may be necessary. A conference, one-half to one hour in length, is held on the topics: admission of private patients; methods of cleaning and preparing

articles for the autoclave, etc.

(e) On the third day, a conference is held on the manner of carrying out protective technique in this building.

2. Continuing program: This consists of: (a) continued supervision of the student and instruction as necessary; (b) planned conferences, including progress discussions.

3. Reports: The head nurse and the ward instructor confer regarding the student's progress and final rating, and write a joint report on which is also included a record of the ward teaching. The instructor makes a brief report on the student's card which is then filed in the "inactive" portion of the file.

GRADUATE NURSES' PROGRAM

1. Orientation of graduates from other schools of nursing—Objectives:

To assist the new staff member to adjust quickly and easily to the hospital and to the ward, and thus to promote her happiness and

efficiency.

Method: The instructor orients the new graduate in much the same way as the student except that she gives more detailed assistance to the new graduate. Her patient assignment is usually light on the first day, and the instructor conducts her on a tour of the ward, the building, and, if possible, the hospital. Conferences are held every day for the first week to introduce the graduate to the procedures of the hospital, methods of charting, protective technique, method of admitting and of discharging patients, etc. The daily work of the graduate is also followed and assistance given as required.

2. General staff nurses' program —

Objectives:

(a) To promote better nursing service through securing greater standardization of nursing practice at a uniformly high level.

(b) To assist in the professional growth and development of the general staff nurse.

Method: One or two conferences, one-half hour in length, are scheduled each week, and attended by groups of two to four graduates. Topics discussed have included: new drugs and treatments; demonstration of

new or unfamiliar apparatus; nursing service problems; routine procedures and techniques, etc. addition, groups of staff nurses have visited the x-ray department and have attended clinics in the fever therapy department. Orientation conferences have been given routinely. This program is felt by the participants to be of value. However, it is still comparatively undeveloped, and we look forward to the time when it will become more vigorous, with the nurses themselves taking the lead in preparing material and leading discussions. Such individual activity would undoubtedly make the program of more real and lasting value to the individual.

3. Special nurses: At the request of the supervisor of nursing, the instructor posted notices offering to assist in the orientation of special nurses unfamiliar with this hospital, and to give or to secure such other information as might be required. Assistance has been given to nurses returning to active nursing after periods of inactivity. This aspect of the program could be developed greatly if the time permitted.

SUBSIDIARY WORKERS' PROGRAM

Nurses' aides: The ward instructor has given a brief period of instruction to nurses' aides and assisted in the supervison of this group.

Ward aides: The instructor has assisted in the orientation and in-

struction of ward aides.

Maids: The instructor teaches and supervises the work of the maids in rooms where full isolation technique

is necessary.

The ward instructor finds her work most interesting, stimulating, and satisfying. Valuable assistance, cooperation and encouragement from the superintendent of nurses, the supervisor of nursing and her assistant, the head nurse, and the teaching department, have made it possible for this program to become established and to develop. It is our hope that it may gain greater strength and effectiveness as time goes on.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Emploi du B.C.G.

GEORGINE BADEAUX

La vaccination contre la tuberculose par l'injection, l'ingestion ou scarification du B.C.G., ou bacille Calmette et Guérin, semble bien avoir traversé victorieusement la phase expérimentale et critique, si on en juge par les articles, les enquêtes, l'attention du monde médical, et de sa presse de plusieurs pays. Vingtcinq années de patientes recherches ont mis en lumière sa valeur comme préventif de la tuberculose: des statistiques nombreuses, recueillies dans différents pays, notamment en France. en Suède, au Danemark, en Norvège, donnent lourdement raison aux disciples de Pasteur, de Koch, Weill-Hallé, Turpin, Calmette et Guérin.

D'abord donné exclusivement aux nouveaux-nés et dès leurs premiers dix jours d'existence, voilà que le B.C.G. prouve de l'efficacité protectrice chez les adultes anergiques. En France, le Ministère de la Santé a fait des expériences affirmativement concluantes dans les écoles d'infirmières et d'assistantes sociales, de même en Norvège et, plus près de nous, en Saskatchewan. Les Etats-Unis s'y intéressent enfin et mettront bientôt sur pieds une vaste organisation expérimentale pour eux, en vaccinant 100,000 personnes dans les états du Sud, où la mortalité par tuberculose a un pourcentage élevé. (Time)

Il n'est pourtant pas éloigné le temps où les déclarations contradictoires, la confusion des faits, des

opinions diverses émises avec autant d'aplomb, désarçonnaient l'observateur et le laissaient dans l'incertitude. Les infirmières hygiénistes, uniquement dévouées à la lutte anti-tuberculeuse, tel les infirmières du Service Social de l'Institut Bruchési, ne peuvent avoir oublié les impasses malheureuses traversées quand le médecin de famille ne secondait pas la prescription du B.C.G. à des nouveaux-nés. En plus de déplorer la perte de protection pour ces enfants de familles contaminées, quel déplaisir pour l'infirmière de ne pas pouvoir affirmer au directeur que 100 pour cent des enfants nés dans leurs foyers visités étaient immunisés!

On a donné une publicité profuse aux enquêtes, aux statistiques, aux déductions scientifiques décrites par des autorités médicales dans plusieurs revues, aussi cet article ne veut aucunement répéter la composition du vaccin, la technologie, l'obligation de la revaccination périodique, encore moins les inconvénients des alternances allergiques et anergiques. Il veut très simplement mettre à jour l'emploi du vaccin B.C.G. dans al lutte anti-tuberculeuse à Montréal de 1926 à nos jours.

DEBUTS DU B.C.G. A MONTREAL C'est en 1921 que Calmette administra le premier vaccin à un être humain; en 1924, l'Institut Pasteur de Paris était prêt à faire la diffusion du vaccin en France, sur demande.

JULY, 1947

Les relations culturelles de notre université canadienne-française pliquent que dès 1926, donc, très près du début, le Département de Bactériologie de la Faculté de Médecine de l'Université de Montréal cultiva une source de vaccin apportée de l'Institut Pasteur de Paris par le Docteur Petit. Les étudiantes de l'Ecole des Infirmières Hygiénistes, alors appelée "Ecole d'Hygiène sociale appliquée," furent les pionnières de la vaccination par B.C.G. en Amérique. même année on vaccina une centaine de bébés, et sous les auspices du Conseil National de Recherches, le Service du B.C.G. de l'Université de Montréal entreprit le travail statistique. Minutieusement, tous les détails médicaux et sociaux du vacciné et de son entourage furent notés: la même méthode est en cours aujourd'hui. Environ 400 familles sont ainsi surveillées, depuis cette époque, au point de vue de l'incidence de contagion tuberculeuse, et surtout pour faire l'éducation et obtenir l'examen pulmonaire périodique des vaccinés et des non-vaccinés, les témoins. A date, les résultats sont favorables à la vaccination dans la proportion d'un décès chez les vaccinés contre cinq chez les non-vaccinés.

Les étudiantes de l'Ecole des Infirmières Hygiénistes sont heureuses d'être les ouvrières de la première heure, de même que les infirmières hygiénistes canadiennes-françaises qui font la lutte à la tuberculose, à Montréal. Les infirmières de l'Assistance Maternelle ont aussi été propagandistes de cette vaccination, de même que les hôpitaux canadiensfrançais sur prescription médicale et

autorisation des parents.

A l'Institut Bruchési, depuis 1926, les infirmières sociales favorisent l'immunisation. Dans leurs nombreuses familles surveillées, durant l'année 1945, 141 enfants sont nés, 115 reçurent le B.C.G., soit 81.5 pour cent.

LA CLINIOUE DU B.C.G.

Toute infirmière sociale en tuberculose reconnaît comme premier devoir l'éducation du malade et de sa famille. Cette éducation est particulièrement importante quand elle protège la vie du nouveau-né. L'efficacité du vaccin B.C.G. est attachée à de nombreux facteurs: l'intégrité du vaccin, la technique d'administration, puis et surtout, l'isolement du vacciné jusqu'à l'établissement évident de son allergie. Avant l'année 1934, l'éducation que l'infirmière sociale donnait aux mères ou aux gardiennes de l'enfant était la seule garantie de cet isolement. Si donc les statistiques couvrant la période 1926 à 1939 sont à l'avantage du vaccin et que l'isolement ou la non-contamination familiale du nouveau-né est essentielle durant au moins deux mois, de quel poids cette éducation pèse-telle dans la mesure du succès!

Depuis 1934, une clinique d'isolement est ouverte aux nouveaux-nés; au numéro 2427, rue Létourneux, un immeuble spacieux est aménagé pour recevoir 80 enfants. La puériculture est souveraine; des spécialistes pédiâtres régissent l'administration et une école de puériculture pour jeunes filles. Quand les parents consentent à la séparation, et c'est un devoir de les faire consentir dans l'intérêt de l'enfant, le nouveau-né est sorti du milieu contaminé dès les premières heures de son existence pour revenir chez lui dans un état allergique, c'est-à-dire à trois ou six

Les statistiques de notre province en fait de taux de mortalité par tuberculose plongent tout québecquois dans une sombre confusion; cependant, réjouissons-nou d'avoir eu foi dans la science de Calmette et Guérin, une foi qui a déjà sa récompense dans le salut de nombreuses vies d'enfants et une foi qui a dressé la clinique du B.C.G., seule organisation du genre en Amérique.

Avec l'oeuvre Grancher, qui est le placement familial à la campagne des enfants de milieu tuberculeux de 1 à 12 ans, la Clinique du B.C.G. apporte souvent la solution aux problèmes familiaux et sociaux, malheureusement, les nécessiteux n'en bénéficient pas tous parce qu'on rencontre des objections d'ordre senti-

mental et financier plus ou moins difficiles à vaincre.

Quand la mère est tuberculeuse, la séparation s'impose et le placement du nouveau-né à la clinique offre une heureuse opportunité, mais que le père, ou le frère, ou la soeur soient les bacillifères du foyer, les parents ripostent sensément: "Placez le malade, c'est lui qui nécessite des soins que nous ne pouvons lui donner." L'isolement ou la non-contamination de l'enfant demeure le fruit de l'éducation, de l'enseignement de l'hygiène, et aussi d'auxiliaires éloignés. aides importants qui sont l'amélioration des conditions de logement, la disparition des taudis, et l'augmentation du salaire familial.

Assainissements des Foyers Dans l'armement anti-tuberculeux, la vaccination par B.C.G. est au chapitre de la prophylaxie: "Pour sauver le ver à soie," a dit Pasteur, "sauvons le cocon." Elle n'est pas cependant une arme de combat comparable au lit de sanatorium. Nul ne contredira que la tuberculose se combat par le lit au sanatorium qui fait l'assainissement des foyers, de la population par la guérison et la réhabilitation des malades.

Sans chercher dans les statistiques et expériences étrangères à notre pays, voyons tout près de nous la province d'Ontario qui, tout en ignorant la vaccination par B.C.G., a baissé à 26 par 100,000 de population son taux de mortalité, mais sachons qu'elle dispose de 3.3 lits par décès, alors que nous, dans le Québec, n'avons que 1.5.

C'est de la simple logique de penser que la vaccination par le B.C.G. donnera son maximum de protection (pas 100 pour cent, nul vaccin ne le donne) et sans exiger un démembrement de l'unité familiale quand les foyers seront assainis, quand cette augmentation de résistance à l'infection tuberculeuse que le vaccin donne aura à parer aux contaminations aléatoires dans les relations interhumaines, sociales ou professionnelles.

In view of the present widespread interest in B.C.G. vaccination, it is gratifying to recall that the students in the school for graduate nurses of the "Université de Montréal" were the pioneers in America in this movement. In 1926, five years after Calmette used his vaccine for the first time on a human being, one hundred babies were vaccinated in the school's health centre, and since that time records have been kept which show very encouraging

results. In 1934, an isolation clinic for newborn babies from tuberculous families was opened in Montreal. Here the babies are vaccinated and they spend from three to six months in the clinic, depending on the need. This clinic, in combination with the Grancher System, which safeguards older children who are contacts, would seem to offer a solution, in part at least, to the problem of prevention of tuberculosis in the Province of Ouebec.

The Canadian Citizenship Act Analyzed

THE ACT of the Dominion Parliament "respecting citizenship, nationality, naturalization, and Status of Aliens" was officially proclaimed on January 1, 1947. The press across the Dominion has given prominence to the ceremonies attending the granting of the first Certificates of Citizenship, and it is interesting to note that one of the terms of this Act

gives the Courts authority to continue to make the granting of such certificates a suitably dignified and impressive ceremony. Those of us who have ourselves become naturalized know only too well the effect of the off-hand, almost totally disinterested procedure that formerly accompanied this exceedingly important step, and it is to be hoped that the Courts

will avail themselves of the opportunity they now have to make the matter of becoming a citizen of Canada something to be remembered with pride.

The Act itself, for such an important piece of legislation, is not long and has been conveniently set up in nine separate parts, some of which are briefly analyzed below.

In a commentary on the Act and its terms appearing in the "Municipal Review of Canada," Bernard Ross, K.C., points out that a "citizen" is in a sense superior to a "subject." This distinction appears in the Act itself (Part IV, Sec. 25 and 26) when it is stated that "a Canadian citizen is a British subject," and . . . "is entitled to all the rights, powers and privileges, as well as the obligations, duties and liabilites of . . . a citizen." These privileges and obligations are not set out in detail, but in placing them in juxtaposition, the essence of the meaning of citizenship is strongly implied, which gives to the Act a moral fibre that is inspiring.

Part I, perhaps the most protant part of the Act, follows the usual definition of terms, and sets out clearly the right of Canadians to declare themselves as Canadian citizens. Legal phraseology usually robs the content of any Act of any literary value — by which we mean the spiritual and emotional overtones that the written word can be made to convey — but Section 3, which deals with these new-found rights, is an exception surely. It reads like this: ... "Where a person is required to state or declare his national status, any person who is a Canadian citizen under this Act may state or declare himself to be a Canadian citizen, and his statement or declaration to that effect will be a good and sufficient compliance with such requirement." Bravo!

Now, under the Act, who is a Canadian citizen? In the case of natural-born Canadians, here it is: (Section 4)

The following persons, born before the coming into force of this Act, are natural-born Canadian citizens:

- (a) Any person born in Canada or on a Canadian ship, who has not become an alien at the time of the coming into force of this Act, and
- (b) Any person born outside of Canada, ... whose father, or in the case of a person born out of wedlock, whose mother
- 1. Was born in Canada, or on a Canadian ship, and had not become an alien at the time of that person's birth, or
- 2. Was, at the time of the person's birth, a British subject who had Canadian domicile, (5 years residence), if, at the time of the coming into force of this Act, that person had not become an alien, and has either been lawfully admitted to Canada for permanent residence, or is a minor.

Persons born in Canada after the commencement of this Act-of Canadian parentage — are automatically citizens, but if they are not of Canadian parentage, they may, after reaching twenty-one years of age, make a declaration thay they wish, or do not wish to assume Canadian nation-On the other hand, a child born outside of Canada of Canadian parents must be registered with the Canadian Consulate in that country, or with the Secretary of State, if their parents wish the child to have Canadian citizenship upon reaching his majority.

Every foundling, first found as a deserted infant in Canada, shall be deemed to have been born in Canada until the contrary is proved. And where a child is born after the death of his father the child is deemed to have been born immediately before the death of his father.

Part II deals with those who are not natural-born Canadians. The Minister (Secretary of State) has the authority to grant a Certificate of Canadian Citizenship to a person who:

- (a) Was granted, or his name was included in, a certificate of naturalization, or
- (b) Was a British subject who had Canadian domicile, or
 - (c) In the case of a woman, if she
- 1. Before the commencement of this Act was married to a man who is a natural-born Canadian citizen, or
- At the commencement of this Act is a British subject, lawfully admitted to Canada for permanent residence.

For those who are not British subjects and have not become naturalized, the method of acquiring Canadian citizenship is as follows:

A declaration of intention to become a Canadian citizen must be filed with the Clerk of a Court (Superior, Circuit, County or District Court) not less than one year and not more than five years prior to the date of his application. When making application it must be proved to the Court's satisfaction that he has been lawfully admitted to Canada for permanent residence, has resided continuously in Canada for a period of one year immediately preceding the date of application (except for members of the Armed Forces who may have been absent on duty); that he is of good character, has an adequate knowledge of either the English or French language, (or if he hasn't such knowledge that he has resided continuously in Canada for more than twenty years); that he has an adequate knowledge of the responsibilities and privileges of Canadian citizenship; and that he intends, if his application is granted, either to reside permanently in Canada, or to enter or continue in the public service of Canada or of a Province.

British subjects may obtain a certificate on application, on payment of \$1.00 (not \$5.00 as originally announced in the press), members of the Armed Forces obtaining them free of charge. The Minister has discretion to grant a certificate where doubt exists, and has authority to refer any application back to the Court for a hearing.

Part III deals with the loss of Canadian citizenship should a Canadian living outside of Canada, and not being under a "disability" (i.e., is not a "minor, a lunatic or an idiot"), by any voluntary or formal act other than marriage acquire the nationality of another country, he ceases to be a Canadian citizen. A citizen of Canada serving in the Armed Forces of any other country when it is at war with Canada loses his right to citizenship. Where the responsible parent ceases to be a Canadian citizen, the child thereupon ceases to be a Canadian citizen, but if the child chooses, after becoming 21 years of age, he may make a declaration and thereupon become a Canadian citizen. You do not lose your Canadian citizenship if you are a Canadian woman and marry an alien.

Section 19 authorizes the Governor-General-in-Council to revoke for adequate cause the citizenship acquired by anyone not a natural-born Canadian, in which case every latitude for adequate defence is provided.

Part IV, dealing with the Status of a Canadian citizen, was reviewed in the third paragraph of this summary.

Part V deals with the Status of Aliens, who may own property, but who may not hold public office nor have the franchise, may not own a Canadian ship, nor have any of the rights or privileges of a citizen. Section 30 within this part provides that aliens be triable at law.

Part VI deals with the procedure and evidence required in acquiring a certificate, and in taking the Oath of Allegiance.

Reprinted with permission from British Columbia's Welfare.

The Memorial at Ottawa

During the thirteenth general meeting of the Canadian Nurses' Association held in Ottawa the third week in August, 1926, an unusually impressive ceremony took place — the unveiling of the Memorial to the forty-seven Canadian nursing sisters who had given their lives during

World War I. A full account of this ceremony was published in the October, 1926, issue of the *The Canadian Nurse*. Many of the nurses of Canada have never had the opportunity to visit Ottawa and view the beautiful sculptured panel in the Hall of Fame. For these and to refresh the memories



The Memorial to the Canadian Nursing Sisters

of the older nurses who were instrumental in raising the funds twentyfive years ago to erect this Memorial, we are reproducing the original picture taken after the unveiling. The inscription reads as follows:

Erected by the nurses of Canada in remembrance of their sisters who gave their lives in the Great War, nineteen fourteeneighteen, and to perpetuate a noble tradition in the relations of the old world and the new.

Led by the spirit of humanity across the seas woman by her tender ministrations to those in need has given to the world the example of an heroic service embracing three centuries of Canadian history.

Miss Jean E. Browne, as president of the Canadian Nurses' Association, presented the Memorial to the people of Canada from the nurses of Canada. In making the presentation, Miss Browne said:

In order to explain the Memorial which has been erected in their honor, it is necessary to sketch briefly the background of the history of nursing in Canada. Nursing was introduced into Canada almost three hundred years ago by two devoted French women — Mademoiselle Mance and Madame de la Peltrie. These ladies left the civilization of the Old World to come to the little colony that was then called New France, and they established hospitals where the cities of Quebec and Montreal stand today. Nursing at that time was carried on entirely by members of religious orders in the face of hardships and perils which it is difficult even to imagine today.

From a scienti ic point of view, the nursing of today has very little in common with the nursing of three hundred years ago, but we believe that the tradition of courage and loyal-ty and sacrifice has come down to the present generation of Canadian nurses from

those brave early pioneers. I think you will agree with me that the quiet everyday tasks of the nurse require courage and devotion beyond that of the ordinary individual.

When the call of the country came in 1914. large numbers of Canadian nurses volunteered for service overseas and, until the end of the war, there was always a long waiting list ready to be called. The Canadian Nurses' Association is proud of the record of the Canadian Army Nursing Sisters. Whether facing the perils of the sea on transport duty, or enduring the heat and extreme discomforts of Gallipoli, in the dangers of the clearing stations near the fighting line, or in the huge base hospitals in France, in the exhausting duties of the base hospitals in England, or in the more prosaic work of the base hospitals in Canada, we believe that the Canadian Army Nursing Sisters acquitted themselves with honor at all times. Of some of them the great sacrifice was demanded, and they were faithful unto death. These the nurses of Canada revere.

At the close of the war, it was felt in the Canadian Nurses' Association that steps should be taken to give this reverence some tangible form that might be left for posterity, so a plan was formulated to raise a fund to erect a Memorial. I think I may say to you that this Memorial has been raised through the independent efforts of some ten thousand organized nurses in Canada, and we believe that this sculptured panel, which has been placed in the Hall of Fame, will typify to some degree at least, through the fine beauty of line and the purity of its marble, the nobility of those nursing sisters who were valiant and unshaken even in the face of death.

We want the people of Canada, both those of the present day and those of the great future, to share with us our exalted pride in our glorious dead.

Preview

The problem of the care of the chronically ill and aged is one which has become more and more involved during recent years. Crowded living accommodation in the homes frequently necessitates some form of institutional care for this group, who range from those who are ambulatory and able to manage with a negligible amount of nursing care, to those who are bedfast and helpless. Next month we will focus our attention on this problem in a series of articles headed up by

Sarah B. Gelbach who sketches in the outline of the needs of this group. Three nurses on the staff of the Runnymede Hospital, Toronto — Edith Rowe, Jane LeWarne, and Jessie Wilson—describe the details of nursing care. Muriel F. Driver writes of the value of carefully guided occupational therapy for these people. Rounding out this series, we present Anne B. Connor's consideration of the educational value to the student nurse of training in this care.

Notes from National Office

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association was held in Montreal on April 28-30, 1947. Those present included: Miss R. Chittick, president; Misses E. Cryderman, E. Mallory, M. Myers, Pettigrew, Macleod, Kay, McArthur, Connor, Emerson, Burton, Grady, Fidler, Flanagan, Ellis, Upton, Walker, Wright, Law, Watson, Mmes D. Harrison and L. MacDonald, Rev. Sisters D. Lefebvre, Clermont, Columkille, Mary Beatrice, Mary Kathleen, St. Gertrude, Mary Irène, Valérie de la Sagesse, Misses Hall, Cooke, and Kerr.

All provincial associations were represented at this meeting.

Highlights of Reports

General Secretary's report: The secretarial staff at National Office obtained data concerning requirements for registration from each provincial registrar and prepared a report for the General Council of Nurses for England, Scotland and Wales, the Royal College of Nursing, and the National Council of Nurses of Great Britain.

A questionnaire to determine the interests of nurses and to receive suggestions for possible activities was prepared by the secretarial staff at National Office and sent to the provincial associations for distribution.

Financial assistance to nurses of the Netherlands to the amount of \$1,130.40 has been provided by the provincial associations to bring two delegates from the Netherlands to attend the I.C.N. Congress. Our objective was \$1,500.

The Deputy Minister of National Health has advised National Office that the request for the sum of \$4,375, in each of the fiscal years 1946-47 and

1947-48 for administration of the school of nursing grant, has been recommended to the Minister of National Health and Welfare for inclusion in the estimates for the coming year. He has every reason to believe that this money will be granted.

Excerpts from the press clippings are being prepared each month and sent to provincial nurses' associations

by National Office.

A total of five hundred replies to letters of inquiry and twenty thousand pieces of publicity have been sent out in response to individual and provincial requests for information

about nursing.

Questionnaires: (1) In an endeavor to determine the number of high school students who are interested in becoming nurses, questionnaires were sent to the nine provincial departments of education. (2) A spot study of twenty-six representative hospitals, to determine the nurse-patient ratio, was prepared. From the information obtained, we were able to determine the percentage of various types of nursing service personnel in hospitals. Post-graduate course outlines, now being offered by university hospitals and public health organizations in Canada, are being revised and brought up-to-date.

Six parcels of used shoes and stockings have been sent via mail to Greek nurses, a total of forty-eight pairs of shoes and several pairs of stockings. Since this report was prepared we have shipped through the Greek War Relief twelve boxes of used shoes. Instructions have been issued to deliver these boxes to the State School for Nurses, St. Lampsakou, F. 7, Athens, Greece.

Seventeen copies of used Proposed Curriculum and Supplement have been sent to the devastated countries of Europe, to aid instructors in schools

of nursing.

Notes from National Office: The question has frequently been raised regarding the release to The Canadian Nurse, under "Notes from National Office," of information concerning current developments in nursing. The policy has always been to delay publishing any such information until cleared through the Executive Committee. Consequently, there is an accumulation of material for publication in the issues immediately following executive and general meetings with an intervening period when little information is available. The complaint on the part of nurses in general is that the information when released is no longer news. Consideration was given to a revision of this system and it was decided that the policy of releasing news concerning developments in nursing earlier, as suggested, be endorsed.

Treasurer's Report

The general secretary was appointed

general secretary-treasurer.

The membership fees paid in 1946 were based on the membership at December 31, 1945, whereas under the revised by-laws the fees which are payable quarterly in 1947 will be based on the membership for the respective periods in that year. It was necessary, therefore, to adjust the fees for 1946 to the basis of the 1946 membership. For example, if there was an increase in the membership of the provincial association at December 31, 1946, over that of December 31, 1945, an adjustment in membership fees was necessary at the rate of \$1.00 per member for that difference. refund was made by the Canadian Nurses' Association at the same rate for any decrease in membership in the above-mentioned period. Such adjustments have been made on the basis of the accompanying comparative statement of membership in the various provinces.

The first instalment of the 1947 membership fees is payable April 1,

based on membership at March 31, 1947.

Committee on Educational Policy

Subsidiary nursing group: This committee sat as a whole and considered the correspondence, and discussed the question of name, uniform, and insignia for such trained workers. No definite policy was decided upon.

Demonstration School Administration Committee: At the sub-committee meeting held in January, 1947, Miss Nettie D. Fidler, who had been recommended by the Administration Committee for the position of director of nursing of the Demonstration School, was asked to investigate the hospitals considered suitable for this school.

Miss Fidler presented reports of her visits to the various hospitals. It was realized that before final arrangements could be made with any board it would be necessary to have the assurance of full registration privileges for the graduates of such a Demonstration School in the province concerned.

In Quebec, the new Act of 1946 necessitates a three-year course of nursing and any school with less could not be certified in the province. The waiver clause, however, would allow the registration in Quebec of such students, if they were registered and in good standing in another province.

Schools of nursing in Ontario are at present under consideration but no definite decision has yet been made.

Miss Fidler's appointment as director of the Demonstration School was confirmed.

Committee on Labor Relations

The work of the committee is concerned with.

1. Methods of collective bargaining for nurses.

2. The relationship of nurses to trade unions.

 Interest in Dominion and Provincial Labor Department Regulations that affect or may affect nurses.

Collective bargaining for nurses: An investigation proved that it was not legally possible for the provincial

Province	Membership 1946	Increase in membership over 1945	Decrease in membership over 1945
Alberta	1,936	113	
British Columbia	3,925	349	
	· ·	349	_
Manitoba	1,788	_	6
New Brunswick	896	47	
Nova Scotia	1,698	153	
Ontario	6,004	_	1,178
P. E. Island	159	14	
Quebec	5,701	443	
Saskatchewan	1,620	107	_
Total	23,727	1,226	1,184

Net increase in 1946 membership over 1945, 42.

associations in the majority of provinces to act as bargaining agents. The committee felt that some other method of collective bargaining for nurses should be devised by which this responsibility could be kept within the professional group. According to information available, at least two of the provinces to date have had representatives of the provincial association certified as bargaining agents for groups of nurses.

Relationship of nurses to trade unions: As a result of the study of the relationship of nurses to trade unions, the committee again expressed the opinion that affiliation with a union could not offer to nurses the understanding and strength that they have in their own profession, and that the organization of trade unions, with the use of a strike as a legal weapon of collective bargaining, is not applicable to nursing service.

There are several instances already commented upon in committee reports of nurses becoming affiliated with trade unions through joining employees' associations. In some of these cases, we feel the nurses would have been better advised to have taken direction from their provincial associations in organizing along the lines suggested for their profession, while others, we realize, joined because it was the only way available to them for finding solutions to their problems.

The following excerpt from a letter refers to a situation bearing some similarity to the Willesden incident but occurring in our own country:

The local problem concerning public health nurses in the employ of the city of Toronto is still giving cause for concern. In December, a memorandum was presented to the mayor urging that the claims of professional groups be recognized and that the compulsory union membership order be amended to exclude them. Yesterday, our legal counsel, our president, and the convener of the Advisory Committee to Local Nursing Groups, along with representatives from the medical, dental, and professional engineer groups, appeared before the City Council to

ask specifically that, when the union shop agreement with the Municipal Employees' Union is renewed in April, these groups be excepted from the terms of the agreement and that no compulsion be exercised either for union membership or for contributions to the union under the R and Formula.

In Section 10 of the Draft Bill for the Industrial Relations and Disputes Investigations Act, 1947, which it is proposed will be introduced to Parliament by the Federal Department of Labor to replace PC-1003, brought in as a wartime measure to give the Dominion Government more jurisdiction in provincial labor matters, it is provided that if the majority of a group of employees belonging to a craft or profession are organized into a trade union, such union may apply to be certified as a bargaining agent for that group of employees. gaining agents for nurses appointed in that way might, therefore, be outside the nursing associations. After consultation with the legal adviser the following motion was, therefore, passed:

WHEREAS, The Canadian Nurses' Association is of the opinion that only members of the nursing profession are adequately informed to bargain collectively on behalf of that profession;

AND WHEREAS, Section 10 of the first draft of the Bill for the Industrial Relations and Disputes Investigation Act, 1947, proposed by the Federal Department of Labor, does not make specific provision for such representation; therefore be it

Resolved, That the Canadian Nurses' Association request the Department of Labor of Canada that Section 10 of the proposed Act be amended to read as follows:

"10. (1) Where the majority of a group of employees of an employer belonging to a craft or profession distinguishable from the employees as a whole so desire, such group may form a unit for collective bargaining and may apply to the Board to have members of their craft or profession certified as bargaining representatives for such unit.

"(2) The employees in such a unit shall if they so desire be excluded from any other unit for collective bargaining and shall not be taken into account as members of any such unit for any purposes of this Act."

Coverage given nurses by the Workmen's Compensation Act:

ALBERTA:

All nurses employed in provincial government hospitals are protected against accident. Several of the city and municipal hospitals have similar coverage but not all of them. There is no coverage for tuberculosis.

BRITISH COLUMBIA:

All nurses in the employ of the following are protected as far as accidents are concerned: government-aided hospitals; provincial government hospitals; private hospitals; municipalities; provincial government; industries which are covered by the Act.

All nurses employed by government-aided or provincial government hospitals are covered for tuberculosis if found after six months' employment.

NEW BRUNSWICK:

All nurses in the employ of all hospitals, regardless of type, are protected against accident.

Public health nurses in municipalities are not covered.

NOVA SCOTIA:

No employees of hospitals are covered for compensation under the Act.

SASKATCHEWAN:

The following nurses are covered:

All nurses in hospitals, nursing homes, rest homes, homes for the care of the aged, sick or indigent, and the Children's Aid Society. This coverage includes all student nurses.

All nurses employed by the Government of Saskatchewan and by the municipal authorities in Regina, Moose Jaw, and Saskatoon.

All nurses employed in industries covered by the Workmen's Compensation Act.

Coverage under the Workmen's Compensation Act in this province does not include tuberculosis. It has been discussed but the decision was made not to include it.

Unemployment insurance: According to reports received from some of the provinces, unemployment insurance is still giving rise to dissatisfaction among the nurses affected by it.

Loan and Bursary Fund

The Canadian Nurses' Association

wishes to announce that funds are available for graduate nurses to obtain a loan up to \$500 to enable them to take post-graduate work. The demand for nurses with special preparation, both in hospitals and in the public health field, is far in excess of the supply, and an adequate number of well-qualified supervisors, teachers, and administrators in both fields is of paramount importance. These loans are granted to graduate nurses so that they may fit themselves for positions of responsibility and leadership in the nursing profession.

Registered nurses who are in good standing as members of a provincial registered nurses' association are elig-

ible to apply.

The maximum period for any loan is five years. The loan is interest free for a period of three years, and if not repaid in this time interest is charged at the rate of 5 per cent commencing from the date of the third anniversary of the loan and continuing thereafter until payment in full is made.

Repayment of the loan must commence as soon as possible after the completion of the post-graduate course. If the recipient ceases to practise as a nurse, the balance then remaining due must be paid immediately. Any nurse who obtains a loan must agree to serve as a nurse in Canada for a period of one year.

Application forms may be obtained from National Office and will be sent

upon request.

Bursaries are also obtainable for outstanding nurses who wish to do advanced work on a high level. Exceptionally well-qualified graduate nurses who wish to take more advanced work may obtain application forms from National Office.

Resolutions

1. Resolved, That the present pro-

cedure in regard to the handling of securities be followed in all routine matters. In the event of an urgent situation arising, the general secretarytreasurer, with the approval of the president, be given power to act. In the event of the president being unable to act, the approval must be secured of the next-ranking vice-president available. In the event that the general secretary-treasurer is not available to handle such an urgent situation the attorney appointed by the general secretary-treasurer shall immediately confer with the president who shall give permission to act after conference or meeting with the Sub-Executive Committee.

2. WHEREAS, The question has arisen of contributed articles published in *The Canadian Nurse* contravening fundamental philosophies of any recognized group within the asso-

ciation; therefore be it

Resolved, That the Editorial Board be asked to define their policy in re-

gard to this question.

- 3. Resolved, That as a number of the readers of The Canadian Nurse have written to the office of the Journal objecting to certain statements in the article "Guilt and Anxiety as Social Controls" published in the February, 1947, issue, the Executive Committee of the Canadian Nurses' Association request The Canadian Nurse to publish the statement that the views expressed in the abovementioned article are the views of the writer, that they have not been officially endorsed by this association, and that they were presented as the author's own interpretation.
- 4. Resolved, That the thanks and appreciation of this executive be extended to Mr. W. B. Scott, legal adviser, for his help and advice, and to the management and staff of the Ritz Carlton Hotel for their courteous and efficient service.

Notes du Secrétariat de l'A.I.C.

Assemblée du Comité Exécutif

Une assemblée du Comité Exécutif de l'A.I.C. eut lieu à Montréal du 28 au 30 avril.

Toutes les associations provinciales étaient représentées à cette assemblée par les personnes suivantes: Mlle R. Chittick, présidente; Mlles E. Cryderman, E. Mallory, McArthur, Connor, Emerson, Burton, Myers, Pettigrew, Macleod, Kay, Grady, Fidler, Flanagan, Ellis, Upton, Walker, Wright, Law, Watson, Mmes Harrison et L. MacDonald, Rév. Soeurs D. Lefebvre, Clermont, Columkille, Mary Beatrice, Mary Kathleen, Ste-Gertrude, Mary Irène, Valérie de la Sagesse, Mlles Hall, Cooke, et Kerr.

Le secrétariat du Bureau National a obtenu des renseignements de chacune des registraires des provinces concernant les conditions requises pour l'enregistrement provincial et a préparé un rapport pour le Conseil Général des Infirmières d'Angleterre, d'Ecosse, et du pays de Galles, le Collège Royal des Infirmières, et pour le Conseil National des Infirmières de Grande-Bretagne.

Un questionnaire fut préparé par le secrétariat et envoyé aux associations provinciales pour distribution afin de connaître ce qui intéresse les infirmières et recevoir des suggestions dans le but d'y répondre, si possible.

L'aide financière aux infirmières des Pays-Bas a été de \$1,130.40. Cette somme reçue des associations provinciales a permis de faire venir deux déléguées au congrès international.

Le Sous-Ministre de la Santé a communiqué au Bureau National que la demande de \$4,375, pour l'administration des écoles d'infirmières durant les années 1946-47 et 1947-48, a été présentée au Ministre de la Santé et du Bien-Etre Social pour y être inscrite au budget de l'année.

Nous avons raison de croire que cette somme nous sera accordée.

Des extraits de coupures de presse concernant la profession ont été envoyés par le secrétariat aux associations provinciales.

Le secrétariat a répondu à 500 demandes de renseignements et a envoyé 20,000 articles de publicité concernant la profession.

Questionnaires: (1) Dans un effort pour déterminer le nombre d'étudiantes des écoles supérieures, intéressées à devenir infirmières, des questionnaires furent envoyés aux neuf départements de l'instruction publique. (2) Un autre questionnaire fut envoyé à un groupe de vingt-six représentantes d'hôpitaux pour déterminer la proportion existante entre les infirmières et les patients; celà nous a permis de déterminer le pourcentage existant dans diverses catégories du nursing.

Les programmes des cours post-scolaires, offerts par les hôpitaux universitaires et les services de santé au Canada, ont été revisés et mis à la page.

Six colis, contenant des chaussures usagées,

ont été envoyés à l'Ecole d'Infirmières de Grèce, St-Lampsakou, F. 7, Athènes, Grèce. Dix-sept exemplaires usagés du Programme d'Etude et du Supplément, à l'usage des écoles du Canada, ont été envoyés dans les pays dévastés d'Europe afin d'aider les institutrices dans les écoles d'infirmières.

Les contributions payées en 1946 le furent d'après le nombre de membres inscrits le 31 décembre 1945; maintenant, d'après nos nouveaux règlements, les contributions seront payables à chaque trimestre et d'après le nombre de membres inscrits à cette période de l'année. (Voir dans version anglaise le tableau donnant le nombre des membres pour chaque province, etc.)

COMITÉ DE LA POLITIQUE EDUCATIONNELLE

Le Comité de la Politique Educationnelle a siégé dans le but de discuter de la question des aides ou auxiliaires. La discussion a porté sur le nom, l'uniforme, et l'insigne pour ce groupe. Aucune ligne de conduite définitive n'a été adoptée.

Le Comité Administratif de l'Ecole de Démonstration: A une réunion du sous-comité tenue en janvier 1947, Mlle N. D. Fidler avait été recommandée par le Comité Administratif pour le poste de directrice de l'Ecole de Démonstration. On demanda alors à Mlle Fidler de rechercher les hôpitaux convenant à l'expérience de cette école.

Mlle Fidler présenta le rapport de ses v sites dans divers hôpitaux.

Il faut d'abord s'assurer que les élèves diplômées de cette école jouieront des privilèges de l'enregistrement provincial.

Dans la province de Québec, la nouvelle loi de 1946 exige que le cours ne soit pas moins de trois ans. Tout de même il serait possible que les diplômées de cette école soient enregistrées dans la province de Québec si elles sont déjà enregistrées dans une autre province.

Les écoles d'infirmières de l'Ontario sont actuellement à l'étude mais aucune décision définitive n'a été prise.

La nomination de MIle Fidler comme directrice de cette Ecole de Démonstration a été confirmée.

COMITÉ DES RELATIONS DU TRAVAIL

Le travail du comité se rapporte aux questions suivantes: (1) méthodes de contrats collectifs; (2) rapport entre infirmières et syndicats; (3) questions dans les lois et règlements des Ministères du Travail Fédéral et Provinciaux pouvant intéresser les infirmières.

Contrats collectifs: Il semble prouvé, après enquête, que légalement il n'est pas possible pour les associations provinciales, dans la plupart des provinces, d'agir comme agents négociateurs. Le comité est d'avis que d'autres méthodes doivent être adoptées dans les négociations collectives afin que cette responsabilité demeure entre les mains du groupe professionnel. Selon les informations obtenues, à date, au moins deux provinces ont obtenu que des représentantes de l'association soient certifiées comme agents négociateurs pour des groupes d'infirmières.

Relations entre infirmières et syndicats: Après une étude des relations entre infirmières et syndicats, le comité exprime encore une fois la même opinion que l'affiliation à un syndicat ne peut donner aux infirmières la compréhension et la force qu'elles trouveront dans leur profession.

Dans les organisations syndicales, la grève, étant un moyen légal employé pour obtenir des négociations collectives, ce seul fait suffirait pour montrer que cette organisation ne peut convenir aux infirmières.

Dans les rapports des comités, on a cité des cas où les infirmières s'étaient affiliées avec les syndicats en faisant partie d'associations d'employés. Dans certains cas nous sommes d'avis que les infirmières auraient bien mieux fait de prendre des directives de leurs associations provinciales et de ne° pas se départir d'une ligne de conduite professionnelle; pour d'autres groupes nous comprenons bien qu'elles n'avaient pas d'autre moyen pour régler leur problèmes.

L'extrait suivant d'une lettre rappelle la situation, déjà rapportée dans ce Journal, l'Incident de Willesden, mais cette fois la chose se passe dans notre pays:

"La situation des infirmières du service de santé de Toronto est un problème local qui cause encore beaucoup de soucis. En décembre, un mémoire fut présenté au maire le pressant de faire reconnaître la revendication du groupe professionnel et que l'ordre, obligeant le groupe professionnel de faire partie des unions ouvrières, soit amendé.

"Hier, notre aviseur légal, notre présidente, et la convocatrice du comité des aviseurs de ce groupe, des représentants des médecins, dentistes, et d'ingénieurs se présentèrent au conseil de ville afin de demander, que lorsqu'une nouvelle entente sera faite en avril avec l'union des employés municipaux, que ces groupes soient exempts de l'entente et qu'il n'y ait aucune obligation de faire partie de l'union ou d'en payer la contribution."

Dans un projet de loi fédérale, concernant les Relations Industrielles et les Enquêtes sur les Différents, loi appelée à remplacer PC-1003 des lois de mesures de guerre, il est dit que si la majorité d'un groupe d'employés, appartenant au même métier ou à la même profession, sont organisés en union ouvrière, cette union peut être certifiée comme agent négociateur pour ce groupe d'employés.

De cette façon il se pourrait que les agents négociateurs nommés ainsi soient étrangers à la profession d'infirmière. Après avoir consulté notre aviseur légal, la motion suivante fut présentée:

Comme l'Association des Infirmières du Canada est d'avis que seuls les membres de la profession d'infirmière sont qualifiés pour faire des contrats collectifs au nom des membres de leur profession, et comme dans le nouveau projet de loi il n'y a pas les dispositions nécessaires à cette fin, il a été résolu de demander au Ministère du Travail du Canada que l'Article 10 de cette loi se lise comme suit:

"10 (1) Lorsque la majorité d'un groupe d'employés d'un employeur auront un métier ou une profession distincte des employés en général, ce dit groupe peut se former en une unité et peut demander à la commission que des membres de leur métier ou de leur profession soient certifiés comme agents négociateurs pour cette dite unité. (2) Que les employés de cette unité soient, s'ils le désirent, exclus de tout autre groupe pour contrats collectifs et que l'on ne tienne pas compte d'eux comme membre de tout autre groupe pour toutes les fins de cette loi."

Loi des Accidents de Travail protège les infirmières comme suit:

Alberta: Toutes les infirmières employées dans les hôpitaux appartenant au gouvernement provincial sont assurées contre les accidents. Plusieurs hôpitaux dans les villes et des hôpitaux municipaux ont les mêmes assurances, mais pas tous.

Aucune assurance contre la tuberculose.

Colombie-Britannique: Toutes les infirmières employées dans les institutions suivantes sont assurées contre les accidents: les hôpitaux recevant des subsides du gouvernement; les hôpitaux du gouvernement provincial; les hôpitaux privés; les services de santé des villes; les services de santé du gouvernement provincial; les industries soumises à la loi. Toutes les infirmières à l'emploi d'hôpitaux recevant de l'aide du gouvernement provincial, ou appartenant à ce gouvernement, sont assurées contre la tuberculose si la maladie se

déclare après six mois d'emploi.

Nouveau-Brunswick: Dans tous les hôpitaux les infirmières sont assurées contre les accidents. Les infirmières à l'emploi des services de santé des villes ne le sont pas.

Nouvelle-Ecosse: Aucun employé d'hôpital n'est protégé par la Loi des Accidents du Travail.

Saskatchewan: La Loi des Accidents du Travail protège les infirmières suivantes:

Toutes les infirmières dans les hôpitaux, hôpitaux privés, de convalescents, hospices pour vieillards, malades, ou indigents, et les oeuvres de l'enfance. Toutes les étudiantes infirmières sont incluses dans ce groupe. Toutes les infirmières employées par le gouvernement provincial et par les villes de Régina, Moose Jaw, et Saskatoon. Toutes les infirmières employées dans les industries soumises à cette loi. La tuberculose n'est pas considérée comme une maladie donnant droit aux indemnités prévues par la Loi des Accidents du Travail.

Loi de l'Assurance-Chomage: D'après les rapports reçus des provinces, cette loi suscite des mécontentements chez les infirmières qui y sont soumises.

BOURSE D'ETUDE

L'Association des Infirmières du Canada annonce qu'une bourse d'étude de \$500 est offerte, sous forme de prêt, aux infirmières afin de les aider à poursuivre des études post-scolaires. La demande d'infirmières qualifiées dépasse de beaucoup l'offre et un nombre adéquat de surveillantes, d'institutrices, et d'administratrices dans les hôpitaux et en hygiène publique est de première importance.

Ce prêt est fait aux infirmières afin qu'elles puissent se qualifier pour des positions importantes et être des chess de ligne dans la prosession.

Les infirmières en règle avec leur association provinciale sont éligibles et peuvent faire leur demande.

Le prêt est fait pour une période ne dépassant pas cinq ans. Il n'y a aucun intérêt pour les trois premières années; après ce temps un intérêt de 5 pour cent est chargé, et ce, jusqu'à remboursement complet.

Le remboursement doit se faire aussitôt

que possible après que le cours post-scolaire est complété. Si la boursière cesse de pratiquer comme infirmière, la balance sur la somme dûe doit être payée immédiatement.

Toute infirmière qui obtient un prêt doit pratiquer comme infirmière durant un an au Canada.

L'on peut obtenir les formules de demande au Bureau National.

RÉSOLUTIONS

1. Il a été résolu que l'on procède de la façon suivante pour tout ce qui concerne les valeurs de l'association. Dans un cas d'urgence que la secrétaire-trésorière générale soit autorisée avec l'approbation de la présidente à prendre les mesures qu'elle juge nécessaire.

En l'absence de la présidente, l'approbation d'une des vice-présidentes d'après leur rang doit être donnée.

Dans le cas où la secrétaire-trésorière générale serait dans l'impossibilité de régler une situation urgente, que l'avocat nommé par la secrétaire-registraire se mette immédiatement en relation avec la présidente qui donnera les autorisations nécessaires après avoir conféré avec le Sous-Comité de l'Exécutif.

- 2. Considérant la question des articles écrits pour *The Canadian Nurse* qui sont en opposition avec la philosophie fondamentale d'un groupe reconnu dans l'association, il a été résolu qu'il sera demandé au comité de direction du *Journal* de définir sa ligne de conduite sur cette question.
- 3. Des lettres de protestations ayant été reçues à la suite de l'article "Guilt and Anxiety as Social Controls" il a été résolu que *The Canadian Nurse* publierait la déclaration suivante: Que les opinions exprimées dans l'article précité sont les opinions de l'auteur et que l'association n'appuie pas officiellement l'article qui présente l'interprétation de l'auteur.
- 4. Il a été résolu que l'on exprime à Monsieur W. B. Scott, conseiller juridique, l'appréciation du Comité Exécutif et ses remerciements pour les avis et l'aide qu'il a donné; que les mêmes sentiments sont exprimés à la direction du Ritz Carlton pour leur service courtois.

Wigs, made with nylon instead of hair, are in great demand in London, ling, the atrival circles. The preference of nylon over hair wigs hes in the fact that nylon can be dyed to the most delicate shades without losing its lustre.

With UNRRA in Germany

(Continued from page 532)

break loose and float along the ocean fairways.

At a snail's pace we crossed the Channel, and made a landing at the ruined harbour of Ostend. What a thrill to set foot for the first time on the continent of Europe; but what a tragedy to behold the bombed and ruined buildings of that well-known port! Then came all the orderly disorder of disembarkation and, in an hour or so, we were driving towards Brussels where already, the Belgians, freed from the nightmare of years of occupation by the enemy, were spreading an air of resolute gaiety through their streets and cafes.

IN GERMANY

Special road maps with marked and numbered routes leading from Brussels in Belgium to Bad Ovenhausen in Germany, the centre for the moment of the HO of the 21st Army Group, BLA, offered alternative routes to our destination. We chose the one that ran through Louvain scene of massacre and destruction in 1914 and later — across the Dutch border and on to Hatert, Nijmegen, and Arnhem, across the Rhine into Germany through Emmerich and Bocholt to Munster, and then by way of Rheda, Bielefeld, and Herford to Bad Ovenhausen.

At Hatert we had our first opportunity of meeting a large group of UNRRA people waiting, in what had formerly been a prisoner-of-war camp, for allocation to their various posts. Nijmegen had a particular interest to me as a Canadian for in the early morning (we spent the second night there) I walked through the debris of the terribly bombed streets to see the important bridge which the Canadians had so gallantly and successfully defended. It was a curious sensation to be actually in Germany, and to see the tremendous destruction of towns like Bocholt, hardly more than a mass of rubble; the notices on trees, fences, and so

forth, warning of bombs, giving stern orders and prohibitions in English and German and, occasionally, ending with the grim words "Penalty—Death." In spite of its ruined houses and heaps of broken bricks, it was difficult to imagine that this beautiful farming country, where women, children, and a few men were working in the fields and harvesting the crops without the aid of machinery and farm animals, had so recently been the scene of the most savage fighting in the world.

As we proceeded, the devastation became even more intense. I shall neverforget the drive through Munster, which was the first major city en route and which, being an important railway centre, had been a special target for the R.A.F. They had certainly done their job well! At Rheda we joined one of Hitler's famous highways — the autobahn — leading from Cologne to Berlin, and on that beautiful surface quickly reached Bad Oyenhausen to report for duty.

ESTABLISHING HEADQUARTERS

It is not necessary to tell the story of the establishment of our headquarters; the collection of information relative to conditions in the field; the locating of our personnel already on duty there; the winning of the confidence of the military authorities who were in sole command; and attempting always to carry out a constructive and cooperative program. Eventually, by much hard work and by the great administrative skill of our Zone Director, Sir Raphael Cilento, who had originally gone out as chief medical officer, opposition was overcome and a sound administrative structure gradually took shape. On November 27, 1945, an agreement — the first in the three zones and the one on which agreements in the French and American Zones were subsequently based was signed between UNRRA and the Commander-in-Chief and Military Governor of the British Zone

of Germany — none other than Field Marshal Montgomery. In this agreement, responsibilities of the Occupation Authorities and UNRRA respectively were, for the first time, set out on a mutually satisfactory basis.

The British Zone of Occupation in Germany — one of the four into which the country was divided comprises the northwestern and central western parts of Germany from the Danish border south to Cologne. and from the Dutch and Belgian borders eastwards as far as Lubeck in the north and Helmstedt in the south (Gottingen is in the British Zone and Cassel in the American). It covers an area about the size of England without Wales. Situated in it are the great coal-mining areas and the former centres of German industry. The area was said to contain some twenty-two million Germans, and when the war ceased there were over three million displaced persons in this British Zone alone. At the time of our arrival the number had fallen to 860,000 who were scattered over the country in nearly four thousand camps within approximately eight hundred "assembly centres.

ASSEMBLY CENTRES

The distribution of these camps was largely an accidental matter. In the early stages, units of the British Army, seizing towns and bringing under control every German area, had "frozen" all collections of displaced persons and had attempted gradually to assemble these into larger and larger groups. Within a few months, with UNRRA assistance, there were 210 of these assembly centres, comprising slightly more than 800 camps and, within a year, they had fallen to a total of 160, of which UNRRA controlled directly 104. UNRRA teams as they reached the field-and 250 had been sent for most urgently-were allocated each to a small army unit and worked under the direct control of the responsible officer, whether he was a colonel or merely a lieutenant. They had, at the beginning, no contact at all with other UNRRA units and no relation to the headquarters unit. Correction of



JEAN WATT, MARY WADE, MYRTLE LINDSAY

this situation was one of the first requirements.

Each team consisted of a director, various administrative and clerical officers, a doctor, a nurse, a welfare officer, supply officers, cooks, etc., with such increases as were necessary depending upon the number of displaced persons under the care of each team.

The refugees and displaced persons —DPs, as they were called—were collected in the assembly centres and might be as few as 1,500 or as many as 20,000. Naturally enough, the shelter provided was inadequate from the standpoint of room space, sanitation, and warmth, but, considering that the occupation authorities were also responsible for housing their own troops and for providing shelter for the thousands of German refugees who kept pouring into the Zone from the east, the accommodation provided was the best available. this, as in many other instances, the occupation authorities did magnificent work under great difficulties.

Many of the assembly centres were established in what had formerly been German barracks. These were undoubtedly best from the point of view of sanitation, ease of administration, and general living conditions. Psychologically, however, the effect was not good for, necessarily, thou-

sands of people were crowded together under conditions all too similar to those they had experienced during the war as prisoners or forced laborers. The crowded conditions also contributed to the spread of airborne and parasitic diseases, to which further reference will be made later. On the other extreme, there were numbers of centres consisting of many scattered camps quite long distances apart. One assembly centre, for example, contained nineteen camps, the furthest of which from north to south were twenty-five kilometres apart and the furthest from east to west were sixteen kilometres apart! While the objections of overcrowding and concentration camp conditions were not present, lack of transport made delivery of supplies and administrative supervision extremely difficult. A very few centres were established in German villages. which had been taken over completely, or almost completely, by the DPS themselves. This was, of course, the most natural set-up, because programs could be developed precisely as they can in any village community. The disadvantage in this type of assembly centre was that people were so comfortable and so well cared for that they hesitated to leave such surroundings even to return to their homeland, since the homeland itself had become an unknown and distant country.

IMMEDIATE PROBLEMS

The immediate problems were three in number. The first and most urgent was to meet the threat of epidemic diseases; the second was to take over



D.P. medical and nursing staff at Lahde Hospital (Baltics)

from the army some of its responsibilities in respect to displaced persons, really a civilian job; the third was to build up a proper administrative structure to which the army could, with confidence, hand over these responsibilities.

Danger of Epidemics

As mentioned above, overcrowding and poor sanitation, a gross lack of equipment and hospital facilities, and insufficiently trained junior personnel made airborne and parasitic diseases continual threats. Typhus, typhoid fever, diphtheria, scarlet fever, skin diseases - parscabies — tuberculosis. and venereal diseases were all of major importance; epidemics of typhoid and typhus were sweeping some areas; diphtheria of a very fatal type had been prevalent at the end of 1944, and it was feared might again become dangerously common. Scarlet fever was already beginning to show itself. Scabies was prevalent owing to the scarcity of soap, the great difficulty in obtaining ointment for treatment, and the crowding that provided great numbers of cases, all of which prevented immediate treatment and so permitted continued reinfection.

The first attack was made upon the typhus situation, particularly in those areas that constituted the border with the Russian Zone. Since European typhus is a louse-borne disease, the chief measure for control was the use of DDT. As it was impossible to control the movements of DPs, it was necessary to see that on every arrival and departure they were treated by dusting. Though the work was very imperfectly done, there is no doubt that it kept the incidence of typhus to a minimum, and prevented the epidemics which might so easily have occurred.

There were no facilities for immunization against scarlet fever, and it ran its course, but immunization against diphtheria and typhoid was started early. It was felt that if from one-third to one-half of the susceptible portions of the community were successfully immunized, no epi-

demic would result, or, if cases did occur, they would "smoulder" in the community rather than "blaze." This proved to be the case. Since the main period of typhoid incidence was in the spring, inoculation against this disease was made secondary to diphtheria, but the routine of typhus, diphtheria, and then typhoid was not always as clear-cut as this sounds.

Flying squads had been sent into the area earlier for the purpose of picking up wandering DPs and bringing them to assembly centres or, if necessary, to hospitals or feeding stations. This plan was very soon exhausted by the fact that the DPs were cleared from the roads. and the flying squads became of great value in the immunization campaign. Many team doctors and nurses had little knowledge of, or interest in, the public health aspects of the medical care program and often, as a result of their inertia, and also owing to the difficulty of obtaining supplies, the initiative in immunizing was taken by the flying squads. Finally, they were charged to deal directly with this situation, the squads being reorganized and each being provided with a doctor and two medical attendants. They visited the assembly centres and, with the assistance of the team doctor and nurse. demonstrated the method and gave the first series of inoculations. follow-up visit was made later to see that the program was continued, and to give any necessary assistance.

HOSPITALS AND SICK BAYS

The second part of the program—taking over responsibilities from the army — consisted (1) in taking over the Belsen hospital and, ultimately, several other activities; and (2) in establishing proper medical facilities and sick bays in all assembly centres, with a gradual building up towards larger installations in the central sites.

A sick bay had to be set up in each centre, sometimes more than one if the camps making up the assembly centre were far apart. One of the major difficulties was the lack of transport and the consequent slowness



Polish nursing aide demonstrating baby bath to D.P. mother

in receipt of supplies. Each UNRRA team went out equipped with a certain quantity of supplies, but these did not stretch very far in the setting up of sick bays and clinics. The military government and the officers in charge of the various units were very generous if they had supplies on hand. The DPs themselves had secret sources of information, and were quite adept at providing the necessary items of equipment and drugs. No questions were asked as to the source!

From the sick bay, anyone who was really ill was sent to the nearest German hospital, in which a certain number of beds were reserved for DPs and were kept under the supervision of the UNRRA personnel. All maternity cases were supposed to be hospitalized in this manner, but frequently the baby was well on the way before the doctor or the nurse was notified.

In the early days there was a great reluctance to report illness because of the fear of hospitalization. The cruel circumstances of the war had given the word "hospital" a dread significance to many of the DPs. It was only because of their confidence in the health worker and her explanation of the fact that by reporting the first sign of illness the need for hospital care might be

averted, regular treatment facilities

were ultimately established.

The British Red Cross Society had five hospitals caring for displaced persons, and, by arrangement, some hospitals—known as "DP hospitals"—were established and staffed almost entirely by DP personnel. The standards of medical and nursing care in some of the latter were adequate, but, in many, conditions were really alarming. It was very difficult to assess the qualifications of the so-called nurses, and in some hospitals probably not more than one or two of the "nursing" staff had ever had any form

of professional training.

The first major activity taken over from the army was the Glynn Hughes Hospital at Belsen, the notorious Nazi concentration camp which became known throughout the world as a byword for atrocity. When this camp was liberated in April, 1945, there were thousands of sick and dying persons, and the magnificent work done by British Army doctors and nurses, and particularly that of Colonel Glynn Hughes for whom this hospital was renamed, is well known. The hospital had been established at Belsen in the building which had formerly served as a hospital for German officers. It was a 500-bed hospital, containing at the highest occupancy 900 patients; at the time it was taken over by us it had 690 patients. It was staffed by German

doctors and nurses, under the supervision of British officers and nursing sisters. It was a condition of the transfer that the German staff should be retained, and that the UNRRA doctors and nurses would act in a supervisory capacity. There were 7 German doctors and 134 German nurses, of whom 119 were fully qualified. This hospital had a greater number of nurses per patient and a greater proportion of qualified nurses to unqualified nurses than any other hospital I visited in Germany. The care given the patients was of good quality, but Belsen had acquired a notoriety that caused it constantly to be a subject of criticism. One must, in all fairness, say a word of praise for these German nurses, who gave excellent nursing care to the displaced persons under conditions which at times were most humiliating and most difficult. There was much criticism from many sources of the continued use of German personnel but, aprt from the fact that this was the basis upon which the hospital had been transferred, it was not possible to obtain a sufficient number of qualified DP personnel in spite of the many statements made claiming that "hundreds" of qualified nurses were available. The very fact that it was the first large UNRRA responsibility made it necessary to maintain the highest possible standard under existing conditions.

(Concluded next month)

In Memoriam

Blanche Bibby, who graduated from St. Pancras Hospital, Highgate, London, Eng., in 1901, passed away in Vancouver on May 8, 1947. Miss Bibby served for over three years as a nursing sister during World War I. Holding a fever nurse's certificate, she engaged in tuberculosis work in Canada and the United States. She was superintendent of nurses at the sanatorium in Tranquille, B.C., prior to her retirement several years ago.

Enid Lenore Chadsey, a graduate with the class of 1930 of St. Paul's Hospital, Vancouver, died on April 25, 1947, after a brief illness. After engaging in private duty for a time in Vancouver, Miss Chadsey accepted the position as matron of the Abbotsford (B.C.) Hospital. Three years ago she was appointed matron of the Port Alice Hospital on Vancouver Island.

Mrs. Fred Milhim, of Hazel Cliff, Sask., who was a graduate of the Yorkton General Hospital, died recently after a long illness.

Nellie Miller, a graduate from Whitby (Ont.) Hospital in 1923, died recently in her forty-ninth year. Miss Miller had been in poor health for a long time and had been unable to practise her profession.

Jessie Wood Robinson died recently in Saint John, N.B., following a lengthy illness. A graduate of the hospital at Beverley, Mass., Miss Robinson had practised nursing for many years, both in Saint John and Montreal.

STUDENT NURSES PAGE

Gastric Ulcer

SISTER EVELYN CLARE

Student Nurse

Halifax Infirmary School of Nursing, N.S.

A n ambulance case admitted to our department was the focus of our interest. Mr. I, the patient, was a slight, pale, apprehensive, middle-aged man, who had apparently been unwell for a period of months. He confirmed our supposition by stating that he has been suffering from a gastric ulcer for years, but after many increasingly severe attacks the acute stage had evidently been reached.

There are many theories concerning the etiology of the gastric ulcer. Among these, the constitutional factor is fundamentally essential; and, while the role of inheritance is uncertain, ulcers are of frequent instance among parents, brothers, and sisters. Chronic ulcers in men usually occur between the ages of twenty and fifty, supposedly caused by the digestion and destruction of a region of the mucous membrane by the activity of the gastric juice. Irregular living habits, emotional strains and temperaments produce a tension which, through the autonomic nerves supplying the stomach wall, affect a change in 'the mucous membrane so that it may be more easily digested by the gastric juice.

The characteristic symptom of gastric ulcers is pain, which is typically related to food ingestion, and is chiefly of a burning and boring character. This pain is the result of irritation of the lesion by the gastric acid secre-

tion; and the relief obtained from food or anti-acids is due to partial neutralization of the acidity. Vomiting and hematemesis are frequent ulcer symptoms, but are not always present. In addition, tenderness is usually noted in the epigastrium on physical examination; a gastric analysis reveals hyperacidity; and x-ray films show suggestive changes in the organ concerned.

Mr. I was fifty-three years of age, married, with two children. Being a commercial artist, he was constantly under the strain of "meeting deadlines." and found this very nervewracking, especially in his present health. For the past twelve years, he had been suffering from attacks of epigastric pain, becoming of late increasingly more severe, and causing a weight loss of nineteen pounds in eight months. Previous to this attack, relief was obtained from anti-acids and hot milk, but now no comfort could be secured. It is of interest in this case to realize that Mr. I's mother, brother, and sister all suffer from "stomach trouble." His physical examination on admission revealed only one significant finding — that of epigastric tenderness.

On the evening of admission, morphine gr. ½ subcutaneously and codeine gr. ½ orally were administered for pain. Anti-acid powders were also ordered, but the respite from

JULV, 1947 55

pain was short and soon our patient was restless and suffering once more. The following day the first stage ulcer diet was ordered. In our hospital this would ordinarily be as follows:

- 1. Feedings every two hours.
- Alternate feedings of milk, malted milk, and lactose milk.
 - 3. Alternate feedings of milk with egg.
- Anti-acid powder every two hours midway between feedings, with an added amount at bedtime.

I stress "ordinarily" because in this case enforcement of the diet was impossible due to the unco-operative attitude of the patient and his refusal to eat. Only after much resourceful persuasion would he partake of the nourishment.

Mr. I was urged to relax and rest as much as possible for the next few days. A fractional gastric analysis was then performed in which the only pathology noted was "hyperacidity" in both the free hydrochloric acid and total acidity tests. In view of the significance of this test, Dr. M, foreseeing future surgery, ordered the second stage ulcer diet, his aim being to improve the patient's general physical condition, because at the present Mr. I was a "poor operative risk." Foods included in this slightly graded diet were: softcooked cereals, in small servings, custard, gelatin, tapioca, soft-boiled egg, slice of bread and butter. Antiacid powders were taken every hour during the day with a larger quantity at bedtime.

As Mr. I continued to improve physically, the nurse's responsibility was to aid him in every possible way to regain his emotional stability and peaceful attitude of mind. This she accomplished to a marked degree by her truly sympathetic and understanding manner of approaching the nervous temperament to which the past years of discomfort had subjected him. She reasoned quietly with him, stressing the importance of frequent feedings, the monotonous diet, and the necessity of rest. At times her efforts on his behalf were well rewarded; at others, Mr. I

was irritable and indifferent to the acquisition of health and future happiness.

Though confined to bed, there were repeated attacks of epigastric pain often accompanied by vomiting. Pantopon was administered hypodermically for the severe seizures, while demerol was ordered for those less painful. Anti-acid powders and milk of bismuth were continued as the patient required them.

The third stage ulcer diet, now introduced, allowed the patient:

Breakfast: Small serving of cooked cereal, equal parts of milk and cream, piece of buttered toast, weak tea or cocoa.

Dinner: Creamed soup, ounce of minced chicken, crackers, weak tea, milk or cocoa.

Supper: Chicken soup or bouillon, softboiled or poached egg, two pieces of buttered toast, milk.

Midlunches: Choice of eggnog, milk, or flavored milk with crackers.

An x-ray of the stomach was taken at this time, the report of which stated, "the ulcer previously noted in the lesser curve has increased tremendously in size, and measures one and one-half centimeters deep, and over three centimeters long. edges are rolled and there appears to be infiltration of the adjacent stomach wall." Malignant degeneration was feared at this stage. expression, "ulcer previously noted," refers to the x-ray taken one year earlier, when a "penetrating gastric ulcer was seen on the lesser curvature between the pylorus and cardiac end," and also, to that of six months ago, when the ulcer was reported to be larger and plainer, but evidenced no malignancy. From these reports we may remark the rapid progress of the degenerative changes.

Instead of the former dietary problems, Mr. I now presented a more responsive attitude, and soon proceeded to the fourth stage diet which included those foods formerly allowed, in larger servings, with additions of mashed potatoes, strained vegetables, boiled or baked fish and white meat of chicken.

When gastric ulcers fail to heal under adequate medical treatment,

surgery is the necessary alternative. Mr. I's condition was of this character, therefore on the day prior to his operation he received the following preparations:

1. Two intravenouses of saline 1000 cc.,

as a preventive measure.

2. Intravenous of amino acids in distilled water. Amino acids are food, equivalent to digested protein, and are offered as a substitute when the patient is unable to secure adequate protein.

3. Blood was grouped and cross-matched in the event of a possible transfusion.

4. The Levine tube was inserted for lavage of the stomach but this operation was unsuccessful as Mr. I would not retain the tube. Because of this, the Wangensteen suction was ordered on the morning of the operation to remove the accumulated materials, and to provide a clean operative field.

5. A saline enema and a high abdominal skin preparation completed the preliminary

procedures.

After many friendly, candid conversations with Dr. M, Mr. I was completely convinced, and greatly confident that surgery would be the best treatment for his condition. This attitude helped to ensure the success of the operation. On the morning appointed, the final preparations were completed, and pantopon gr. ½ with hyoscine gr. 1/150 was administered as medication. The anesthetic used was sodium pentothal, and the operation commenced.

Through a high left paramedian incision the abdomen was opened. "An indurated mass was felt on the lesser curvature of the stomach, about two and one-half inches from the esophagus. An ulcer was felt in this mass. No definite induration, no stony hardness, no involvement of the peritoneum, and no glandular en-

largement were noted."

The usual surgery for the above findings would be total or subtotal gastrectomy, gastroenterostomy or pyloroplasty but, because of the patient's condition, Dr. M considered a total gastrectomy too formidable and performed a vagotomy. "Both vagi nerves were isolated, and about two inches of each resected with ends ligated." Some years ago, it was

demonstrated, in the treatment of gastric ulcer, that "after section gastric ulcers were of the vagi, not produced by direct electrical stimulation of the tuber centres of the infundibulum," thus theorizing that stimulation to the stomach by the vagus nerve branch was a fundamental cause of the ulcer, and that after section of the nerve no stimulation occurred. The reason for this supposition is based on the fact that the central nerve supply is through the vagus which contains both motor and sensory fibres to the muscles of the stomach. Dr. M's object in performing this newer method of surgical ulcer treatment, in use only within the last decade, was to reduce the hypermotility and hyperacidity of the stomach caused by the vagus, and to afford rest to the part, allowing the lesion adequate environmental conditions for healing.

During the operation, a blood transfusion was given and Mr. I's state throughout was good, as also was his post-operative condition. The Wangensteen suction was resumed for six days, penicillin 620,000 units ordered, and a daily intravenous of glucose and saline administered, all as post-operative measures. In addition to the ordinary nursing care, including daily skin cleanliness, oral hygiene, frequent positional changes, a sympathetic and pleasant manner demonstrated by those in charge of the patient, aided in hastening his

recovery.

A minor complication appeared about one week later, that of occasional attacks of diarrhea, but this symptom had been expected by Dr. M who explained that this was the one debatable point in regard to a vagotomy. He proceeded to treat the condition by a prescription of hydrochloric acid and milk of bismuth, so that when Mr. I was discharged this weakness was well under control. There were also days of extreme nervous irritability and emotional depression which resulted in a refusal to eat or to rest, despite the efforts and solicitude of the entire staff. At times, Mr. I was considered a "difficult

patient," but responded fairly well to gentle and tactful management. After nine days, several sutures were removed, the incision healing by primary intention, and the patient was permitted out of bed for lengthening intervals. During this convalescence, his appetite improved until in a few weeks he was on a general diet, excepting, of course, for flatus-forming, harsh foods. Automobile drives taken with his family were a considerable encouragement for Mr. I.

Another fractional gastric analysis was performed and revealed an almost unbelievable decrease in the stomach acidity. More encouraging still was the x-ray report of this time, just three weeks after his operation, which stated: "There is definite decrease in the size of the ulcer in length and depth. The appearance is that of a rapidly healing ulcer."

On the day of his discharge, Mr.

I presented a very much improved appearance from that of the evening of his admission. Though yet slight in stature, his countenance and general demeanor expressed a certain confidence in his recently acquired freedom from pain and discomfort. At present, Mr. I is enjoying normal health, while yet convalescing, is regaining former weight by means of rest and a nutritious diet, and is considering resuming his work. When Dr. M re-checks the healing progress by x-ray at some future date, we trust it will provide encouragement for the treatment of gastric ulcer by a vagotomy.

BIBLIOGRAPHY

1. Anglo - Canadian Drug Co. Ulcap Therapy. 1945.

2. Blumgarten. Textbook of Materia Medica, Pharmacology and Therapeutics.

3. Hull, Wright and Eyl. Medical Nursing.

The Resuscitation of the Drowned

E. J. PAMPANA, M.D.

It may be said that the method of artificial respiration which is the best known and the most frequently used today is the Schäfer method. In order to obtain effective results, by means of the Schäfer method, it is necessary that elasticity, or, more exactly, muscular tone be maintained. When using this method, the hands are placed close together flat on the back over the loins, the fingers extending over the lower ribs, and a gradually increasing pressure is exerted during three seconds. On relaxing the pressure, the chest resumes its former shape and size, so that the volume of air entering the lungs is equal to that forced out by the pressure. This inspiration is brought about naturally by the tone of the muscles, when they resume the normal position. Unfortunately, in a great many cases where artificial respiration is necessary, muscular tone decreases progressively; this is the case with drowning vic-

tims. Moreover, with the Schäfer method, the weight of the shoulders, the spinal column, the shoulder-bones, and the dorsal muscles opposes inspirations, and constitutes an obstacle which is all the more serious due to the decreased tonus of the respiratory muscles. In fact, it has been suggested that a second operator should help by lifting the folded elbows of the patient whose forearms remain extended. This system is used in the Holger-Nielsen method of artificial respiration—a method which combines forced expiration and inspiration and which, therefore, is not altogether dependent upon muscular tone. This method however, is not yet universally known, although it is used in Denmark, Norway, and the U.S.S.R.

During the recent war, which offered such wide opportunities for the practice of methods for the resuscitation of the drowned, certain criticisms of the Schäfer method were voiced.

For example, Gibbens (1942) wrote that, instead of the normal inspiration to be expected each time he interrupted the pressure, he had the feeling that the thorax and abdomen of the victim "felt like putty."

victim "felt like putty."

By rendering the breathing as independent as possible of the muscular tone, the Eve method (1932) would seem to be recommended for the resuscitation of the drowned. This is the system known as the "rocking method." The patient is placed face downward on a stretcher which has been mounted on either a trestle or support or attached by the sides to two cords suspended from the ceiling. The patient is then rocked on the stretcher at the rate of twelve double rocks a minute, with oscillations of from 60 to 90 degrees. These oscillations displace the weight of the abdominal contents, so that the latter alternately pushes and pulls the diaphragm, by a mechanism comparable to that of a piston operated solely by weight. As a matter of fact, it is the weight which causes expirations and inspirations, and this latter does not in any way depend on muscular The lungs are, therefore, excited exclusively by the diaphragm which, even when completely flaccid, still operates as a piston which is pushed towards the head when the head is lowered, and in the opposite direction when the head and thorax are raised. The diaphragm is the really indispensable muscle for breathing, and the object of the Eve method is to re-establish the working of the diaphragm.

Nevertheless, it is difficult to prove that the rhythmical movement of the diaphragm, in so far as it is caused by this method, induces pulmonary ventilation equal or superior to that caused by Schäfer's method, as Eve and Killick believed to have shown (1933). The results given by them have been subjected to criticism. The solution of this problem is difficult, since the volunteers who submit to artificial respiration tests, by voluntarily holding their breath, frequently do not succeed in maintaining an absolute respiratory passivity for the

whole course of the experiment. Recourse can be had to patients submitted to profound anesthesia, in whom apnea (cessation of breathing), following exaggerated respiratory exchanges for a few minutes, is induced: experimental evidence in this direction, however, is still too scanty. The ideal method would be to experiment on the bodies of persons (who have died unaffected by any disease likely to vitiate the mechanism of the pulmonary ventilation) provided that the corpse is still warm and not yet rigid. All this is easy to imagine but less easy to carry out, although attempts are being made in hospitals to control the Eve method. by combating all the necessary conditions. Finally, there is another way of comparing the efficacy of methods of artificial respiration: that adopted by Hemingway and Neil (1944). They carried out experiments on dogs. in whom action of the respiratory centres had been made impossible, either by the transverse section of the spinal cord between the first and second cervical segments, or by a profound anesthesia with nembutal continued until cessation of breathing. In both cases, of course, the animal dies if not given artificial respiration. These latter experiments, which have confirmed the fact that in order to assess a method of artificial respiration it is not sufficient to limit oneself to a comparison of pulmonary ventilation, have established that with the "rocking" method a higher rate of oxygen absorption was ascertained together with a greater cardiac output and a higher oxygen tension in the venous blood, than in the case of Schäfer's system as applied to dogs.

These results are particularly interesting as they provide us with data concerning the oxygenation of the blood and concerning the circulation, two factors which are as important as mere pulmonary ventilation for the purpose of reviving drowned persons.

The aim of every method of artificial respiration is to maintain or to re-establish the respiratory exchanges in the central nervous system, that is to provide it with oxygenated blood.

Now, in the case of drowned persons. the general hypotonia of the muscles does not facilitate the return of the venous blood to the heart. Schäfer's system obviates this disadvantage by the compression of the abdominal veins, which occurs during the phase of forced expiration. According to its author, the Eve system is an improvement, as it forces back to the heart first the blood of the upper part and then the blood of the lower part of the body, and the valves in the veins prevent a reflux of the venous blood towards the extremities. The alternation of pressure in the thorax caused by this method can also facilitate the filling as well as the emptying of the blood from the lungs, going to the heart. Moreover, Eve believes that the cerebral congestion which occurs every time the head is lowered facilitates the functioning of the respiratory centre, which, according to the experience of anesthetists, restarts

working with difficulty unless it is congested.

In practice, it may not always be possible to apply immediately the "rocking" method to a drowned person who has only just been rescued from the water. It is necessary to begin with one of the manual methods. and generally it is Schäfer's system which is recommended for the drowned, although one might well ask oneself whether Sylvester's method would not sometimes be preferable, since certain experiments on corpses in which rigidity has not yet set in show that the latter system induces a pulmonary ventilation far superior to that obtained by Schäfer's system. In the meantime, the stretcher can be prepared for rocking and the victim may be placed thereon, without of course ceasing manual respiration until rocking has commenced.

Several types of stretchers or devices have been suggested for rocking.

The War Memorial Trust Fund

Elsewhere in this issue, we have reproduced the dedicatory address and the photograph of the Memorial erected to the memory of the nurses who served in World War I. It is proposed to affix a suitably inscribed plaque to this panel to commemorate the nurses of World War II. In addition, the larger, more far-reaching memorial which was decided upon at the last biennial meeting of the Canadian Nurses' Association, that of sending professional libraries to the warravaged countries of the world, awaits your donations. As announced in the February, 1947, issue of this Journal, the provincial allocations for this purpose were as follows:

deliming tot entra pari prime mere	Ce 17 1 17 10 0 11 1
Alberta	\$ 2,000
British Columbia	3,700
Manitoba	2,000
New Brunswick	900
Nova Scotia	1,600
Ontario	10,000
Prince Edward Island	200
Quebec	10,000
Saskatchewan	1,600
~	

Total.....\$32,000

Donations that have been received at the National Office, C.N.A., show the following totals as of June 6, 1947:

Alberta, \$1,022; British Columbia, \$705; Manitoba, \$1,266.50; New Brunswick, \$677.35; Nova Scotia, \$401; Ontario, \$3,103; Quebec, \$78.08; Anonymous, \$6.00. Total, \$7,258.93.

How did your province contribute to the first Memorial? From the report of the late Miss Jean I. Gunn, who was convener of the first committee, we may read in the October, 1926, issue:

"The first estimated cost of the Memorial was \$65,000, but in April, 1923, after the definite site had been decided and a more definite idea as to the actual type of sculptured panel was possible, the estimate was reduced to \$35,000. The objective assigned to each provincial committee was based on the membership of the provincial association and was as follows: British Columbia, \$7,000; Alberta, \$2,350; Saskatchewan, \$2,350; Manitoba, \$1,400; Ontario, \$13,500; Quebec, \$5,600; New Brunswick, \$1,400; Nova Scotia, \$1,400; Prince Edward Island, no definite objective as there were so few nurses to contribute.

Registered Nurses for General Duty at Royal Jubilee Hospital, Victoria, B.C. State in first letter year of graduation, experience, references, etc., and when available. Starting salary: \$140 per month, living out. Yearly salary increases up to \$160 in 4 years. Special post-graduate training—Starting salary: \$150 with increases to \$170 in 4 years. Laundry allowed. A few rooms available in residence. Sick leave allowance, cumulative 1½ days per month. Superannuation. 4 weeks' vacation per year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nursing.

Instructor for small Training School. Private room with full maintenance. Apply, with references and stating salary expected, to Plummer Memorial Public Hospital, Sault Ste. Marie, Ont.

Registered Nurses for General Staff Nursing in Medical, Surgical, and Obstetrical Depts. Operating-Room Nurse and Assistant Night Supervisor. For 100-bed General Hospital in Western Ontario. 8-hour day and 48-hour week. Apply, stating qualifications and salary expected, to Supt. of Nurses, General Hospital, Woodstock, Ont.

Graduate Nurses for Operating-Room, Charge Duty, and General Duty. X-Ray Technician. Apply giving experience, to Supt., Blanchard-Fraser Memorial Hospital, Kentville, N.S.

General Staff Nurses. Initial salary: \$140 per month and laundry. First increment is granted after 6 months. 8-hour day and 6-day week. 3 weeks annual vacation. Apply to Supt. of Nurses, General Hospital, Toronto, Ont.

Registered Nurses (3) for General Duty in 30-bed hospital located in southern interior of B.C. near U.S. border. 2 active surgeons on staff. Gross salary: \$135 per month. 4 weeks' vacation with pay. Generous recreational facilities. Popular summer resort nearby. Apply to Sec., Community Hospital, Grand Forks, B.C.

Graduate Nurses for General Duty. \$145 per month. 8-hour day and 6-day week. For further information apply to Supt., St. Peter's Hospital, Melville, Sask.

Getting Results!

"I thought you might like to know the response to an advertisement for an operating-room nurse which appeared in *The Canadian Nurse* in January and February of this year.

"Five replies were received and a Toronto nurse was selected and planned to come on July 15, but serious illness of her mother made it necessary for her to cancel the appointment. A second applicant was selected from Montreal and she will report on duty August 11.

"We feel that our problem has been satisfactorily solved for us through this advertisement, as all the applicants were suitably qualified to meet the requirements of the position offered.

"Thank you for your help in this matter."

Nursing Sisters' Association

The Toronto Unit joined with other nurses in the Toronto area in the annual Nurses' Memorial Service, held on May 4, and arranged by District 5, R.N.A.O. The Protestant service, held at Metropolitan United Church, was under the direction of the Very Rev. Peter Bryce, D.D., LL.D. St. Michael's Cathedral was the scene of the Roman Catholic service and was conducted by the Rev. Father Hendricks and the Rev. J. W. Dore. About fifteen hundred nurses, including large

groups of students, attended the services.

Several members of the unit attended the I.C.N. Congress held in Atlantic City, including Agnes Neill, Ethel Greenwood, Edna Moore, Doris Kent, Maude Wilkinson, Gladys Sharpe, Helen Heffernan, Ethel Cryderman, Mary Sunley, Alice Ross, Margaret Kennedy, Dorothy Riddell. Misses Wilkinson and Sunley spent a week in New York following the Congress, sitting in at several meetings of the United Nations.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

President ... Miss Rae Chittick, Faculty of Education, University of Alberta, Calgary, Alta Past President ... Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P.Q. First Vice-President ... Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont. Second Vice-President ... Miss Evelyn Mallory, University of British Columbia, Vancouver, B.C. Third Vice-President ... Miss Marion Myers, Saint John General Hospital, Saint John, N.B. Honorary Secretary ... Rev. Sister Denise Lefebvre, 1135 St. Marthew St., Montreal 25, P.Q. Honorary Treasurer ... Miss Lillian Pettigrew, Winnipeg General Hospital, Winnipeg, Man.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Committee on Institutional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing.

Alberta: (1) Miss B. Emerson, 23 Rene LeMarchand Mansions, Edmonton; (2) Miss A. Anderson, Roya Alexandra Hospital, Edmonton; (3) Miss G. Hutchings, Strathmore; (4) Miss Orma Smith, Galt Hospital, Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5 1334 Nicola St., Vancouver.

Manitoba: (1) Miss I. Barton, Veterans' Home, Winnipeg; (2) Miss V. Williams, St. Boniface Hospita (3) Miss D. Dick, City Health Dept., Winnipeg; (4) Miss M. Muir, 16 Gordon Apts., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospita Saint John; (3) Miss Lois Smith, Walker Apts., York St., Fredericton; (4) Mrs. B. Nash Smith, 57 Queen St Moncton.

Nova Scotia: (1) Miss L. Grady, Halifax Infirmary; (2) Sr. M. Beatrice, Glace Bay; (3) Miss M. Shore, V.O.N., Halifax; (4) Miss M. Stevens, Box 345, Amherst.

Ontario: (1) Miss N. D. Fidler, School of Nursing, University of Toronto, Toronto 5; (2) Miss C. Tavener 42 Isabella St., Toronto 5; (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs., Toronto 2; (4) Miss D. Marcellus, 166 Roxborough St. E., Toronto 5.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. Mary Irene, Charlottetown Hospital; (3) Miss E. Wheler, Summerside; (4) Miss M. Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Miss E. Flanagan, 3801 University St., Montreal 2; (2) Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal 25; (3) Miss A. Girard, l'Ecole d'Infirmières Hygiénistes, University of Montreal, 2900 Mt. Royal Blvd., Montreal 26; (4) Miss E. Killins, 3533 University St., Montreal 2.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss S. Leeper, 130-8th St. E., Saskatoon; (3) Miss G. McDonald, No. 5, 2025 Lorne St., Regina; (4) Mrs. E. Lewis, 205 Bliss Block, Prince Albert.

Religious Sisters: Rev. Sr. Columkille, St. Paul's Hospital, Vancouver, B.C.; Rev. Sr. M. Kathleen, St. Michael's Hospital, Toronto 2, Ont.; Rev. Sr. St. Gertrude, Civic Hospital, 1051 Chemin de la Canardière, Quebec, P.Q.; Rev. Sr. M. Irene, Holy Family School of Nursing, 15th St. W., Prince Albert, Sask.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q. Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans Affairs, Ottawa, Ont. Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man. Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta. Committee on Private Duty Nursing: Miss Barbara Key, 123 Bold St., Apt. 56, Hamilton, Ont. Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ont.

EXECUTIVE OFFICERS

International Council of Nurses: 1819 Broadway, New York City 23, U.S.A. Executive Secretary, Miss Anna Schwarzenberg.
 Canadlan Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. Genera Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses: Miss E. Bell Rogers, St. Stephen's College, Edmonton.
Registered Nurses' Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
Manitoba Ass'n of Registered Nurses: Miss Laura Fair, 214 Balmoral St., Winnipeg.
New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.
Registered Nurses' Ass'n of Nova Scotia: Miss Nancy Watson, 301 Barrington St., Halifax.
Registered Nurses Ass'n of Ontario: Miss Maidida E. Fitzgerald, Rn. 715, 86 Bloor St. W., Toronto 5.
Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlotte-

Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bidg., Montreal 25. Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Vol. 43, No. 7

VOLUME 43 NUMBER 8 MONTREAL AUGUST 1947

THE CANADIAN NURSE



Symposium on Chronic Illness

Job Analysis
by M. E. Botsford



Photo by Climo, Saint John See Page 614



OWNED

AND

PHBLISHED

13 4



had on duty, the Government would probably have a brand new class of capitalists to tax. Every nurse, however, realizes that it pays big dividends to obtain rapid symptomatic relief by the use of a tested and effective analgesic.

Tabloid' Brand 'Empirin' Compound is just such a preparation. Its formula has won virtually universal approval for its effective analgesic action, while the purity of its ingredients and careful compounding ensure a rapid, dependable effect. For a trial sample, simply tear out and mail the sample offer below.

Each product contains

'EMPIRIN' (Brand of Acetylsalicylic Acid) gr. 3½
PHENACETIN gr. ½
CAFFEINE gr. ½

TABLOID BRAND

EMPIRIN' TRADE MARK COMPOUND

Please send me without obligation a sample issue of 'Tabloid' Brand 'Empirin' Compound.

SON DEL TO SET IND A TO THE JAN 1987 IN

Name

Address





MILK received at all Carnation evaporating plants must regularly submit to this exacting test. A sample is drawn from the very bottom of the can, then forced through a filter disk. Sedimentary deposit reveals and disqualifies sub-standard milk that violates the Carnation rule of "clean cows, clean hands, clean utensils, clean milk." . . . But this is only one of many tests that insure the quality and uniformity of Carnation Evaporated Milk -- and justify the medical profession's firm confidence in this foremost brand.

HOMOGENIZED with butter at minutely subdivided for easy assi-

FORTIFIED—stradiated in a Vitamin D potency of 400 Int. units per pint.

STANDARDIZED -for uniformity

STERILIZED after beroomly and markedly dimensional discounting the strong treating by twent the except and markedly dimensional aftergration properties.



"From Contented Cores"

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR AUGUST, 1947

Nova Scotia Reviews	589
HEALTH PROBLEMS OF AN AGING POPULATION	591
CHRONIC ILLNESS	594
THE CARE OF THE CHRONICALLY ILL	596
THE STUDENT NURSE AND CHRONIC ILLNESS	599
OCCUPATIONAL THERAPY FOR THE CHRONICALLY ILL	602
WITH UNRRA IN GERMANY	605
JOB ANALYSIS	611
OUTPOST NURSING - A CHALLENGE TO CANADIAN NURSES M. I. Schonberg	615
ETUDE SUR UNE AFFILIATION DANS SANATORIUM DE TUBERCULEUX	619
Notes from National Office	623
Notes du Secretariat de l'A.I.C.	625
Provincial Annual Meetings	626
My Out-Patient Experience	635
Book Reviews	638
News Notes.	645

SAVE MONEY! Buy Ahead for 3 Years

For many months we have been facing the question of advancing our subscription rates to help counteract the increasing costs of publishing *The Canadian Nurse*. Because we were anxious to do our share against the rising prices all along the line, we have postponed this step as long as possible.

It has become evident that we can no longer continue to give you the high quality of service which you have come to expect, at the subscription rates which were originally set in the '20's. Rather than sacrifice any standard of the *Journal*, the increased rates will be put into effect on October 1, 1947. However, this increase in the cost of subscription need not affect you for several years to come.

Before the new rates become effective, you have the opportunity to buy *The Canadian Nurse* ahead at the present low prices. No matter how far in advance your subscription is already paid up, you may purchase another three years for five dollars if you subscribe promptly.

It will be gratifying to know that you need not be bothered with year-after-year renewal notices — to know that you are receiving outstanding value for your dollars — to know that you will receive your copy of *The Canadian Nurse* regularly.

Until October 1, 1947, the subscription rates for the *Journal* are: \$2.00 per year; \$5.00 for 3 years; foreign and U.S.A., \$2.50 per year; student nurses: \$2.00 for eighteen months; \$4.00 for three years.

All cheques, money orders and postal notes to be made payable to *The Canadian Nurse*. Add 15 cents exchange to personal cheques. Please PRINT name and address to ensure accuracy.

Vol. 43, No. 8



DRAX means less washing.. easier washing..at lower cost!

Imagine! One product that can do all this! Protect washable fabrics from dirt, soil and water—thus keeping them clean and fresh-looking longer... make them easier to wash—because dirt does not get ground in to the fabric, rinses quickly away.

All this means cutting down on the size and the cost of your laundry.

And all this DRAX does! DRAX, made by the makers of Johnson's Wax, is actually an invisible, inexpensive rinse that gives uniforms, bedspreads, tablecloths, curtains, the wonderful protection of wax.

They stay clean longer . . . they wash clean easier. You'll find it will pay you dividends to find out about DRAX right now!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

AUGUST, 1947

Reader's Guide

Our guest editor this month is the president of the Registered Nurses' Association of Nova Scotia, Lillian Agnes Grady, B.Sc. Her Irish descent gives her an optimistic perspective on the pressing nursing problems of today. Educated in Dartmouth, N.S., Miss Grady graduated from the school of nursing of the Halifax Infirmary in 1930. A brief experience in private duty, two years of general duty on the obstetrical wards, and three years as head nurse in the delivery room of the Halifax Infirmary gave her a broad picture of nursing needs. In 1936, Miss Grady received a fellowship from the St. Louis (Mo.) University and proceeded with the studies for her degree in nursing education. She has been engaged in the instruction of student nurses at the Infirmary since 1939. Her professional activities have covered a wide range of offices culminating in her election as president of the R.N.A.N.S. in 1946.

"Old age is not a disease, but the disabilities arising from it are. As we overcome these we not only postpone old age but we defeat the suffering and sorrow of old age."- Theodore G. Klumpp. With this thought as our premise, the predominant emphasis this month is being given to the problems related to the nursing care of the chronically ill. We are privileged to introduce this topic with the major portions of the address given by Dr. Edward Hall, president of the University of Western Ontario, London, at the annual meeting of the Victorian Order of Nurses for Canada. Sarah B. Gelbach, who is regional director in southeastern United States for the study of chronic diseases, with her headquarters in the Miami Institute of Neurology, outlines the application of this problem to the nursing profession. Getting right down to a discussion of what the nurse's contribution includes, we have joint authors from the Runnymede Hospital, Toronto-Edith Rowe, Jane LeWarne, and Jessie Wilson. Anne Bernice Connor delved into the problem of teaching the student nurse the essentials of chronic disease care during her course at the McGill School for Graduate Nurses.

Winding up this notable series, Muriel F. Driver, occupational therapist at Runnymede Hospital, describes the value of some form of work both to keep the chronic patients

interested and to assist in improving their general well-being.

How do the people who live in the great stretches of our Dominion, far from the excellent medical services available in our cities and towns, fare when illness or accident strike? What is their source of medical information? Muriel I. Schonberg reveals the difficulties as well as the compensations of nursing in these outpost areas. Her sympathetic understanding of the problems grew out of her extensive experience in ministering to the families in the Peace River and other areas under the egis of the Canadian Red Cross Society.

Continuing their study of personnel policies, the Committee on Institutional Nursing arranged for two of their capable members to study the actual processes of job analysis and evaluation as conducted by the Hudson's Bay Company. Marion E. Botsford demonstrates the diligence with which the observations were made in her article in this issue.

The multifarious undertakings and accomplishments of five of the provincial registered nurses' associations indicate the scope of nursing organization activity across Canada. We commend them to your careful reading. You will note a marked similarity in the topics that are engaging provincial attention. Perhaps one of the most heartening features, in the presentday nursing scene, is the greater interest that the rank and file of our members are taking in their association's activities. We think you will enjoy the display of millinery which the clever pencil of one conventiongoer sketched as she sat and listened to the discussions. "Doodling" of this kind provides entertainment for us all.

In 1944, we set the goal of ten thousand subscribers to the *Journal* by 1946. We missed that goal by a year. Last month's run of 10,300 copies shows how much the *Journal's* mailing list has grown. Distribution figures in the nine provinces indicate an ever-widening reading public. Here is how the figures stood at July 1, 1947: Alberta, 836; British Columbia, 1,208; Manitoba, 541; New Brunswick, 604; Nova Scotia, 567; Ontario, 3,487; Prince Edward Island, 141; Quebec, 1,069; Saskatchewan, 607. Compare these with last month's figures.

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER EIGHT

MONTREAL, AUGUST, 1947

Nova Scotia Reviews

WEBSTER defines retrospection as "A review or contemplation of past events." It is an activity one should indulge in more often, not because it will be an enjoyable pastime—on the contrary, it can be a very depressing experience—but because it will help to judge the past more objectively so that plans for the future may be properly evaluated.

As we, in Nova Scotia, review the events of the past few years, we acknowledge several disappointments. Our hope for an advisory-registrar, and our hope that a post-graduate school for nurses would be opened in Halifax in 1947 remain just that, hopes, for the present. We realize that the time was not ripe for either, and so, with our zeal in no way lessened, we await the opportune time.

In nursing education we are keenly aware of the "trends." We are quite conscious of the fact that many outside of our profession, and some within its ranks, are not quite satisfied with what has been accomplished in nursing education to meet the health needs of the general public. We believe that as a provincial association, we have

some responsibility in the matter, but just where to begin is the question. We are convinced that we shall be benefitting the professional nurses of the future if the educational standards,



LHEIN A. GRADY

both for entrance into Nova Scotia schools of nursing and for registration, are raised. With that thought in mind, the Legislation Committee has been very active although there is no new ilegislation; to show this. We are at the same time conscious of the inequality of standards concerning the admission requirements to enter schools of nursing and, similarly, to become registered in the other provinces of the Dominion. It would seem an excellent idea to have all students meet university entrance requirements, but these vary and one wonders, while trying to revise the Constitution and By-Laws as we are, just what to specify as requirements. so that students will not be handicapped in their choice of a school for post-graduate work. Would Dominion examinations be the answer to the second part of the problem? question has received some study and will receive a great deal more before we arrive at a final decision concerning the proposed revision of our Act.

For some time, the advisability of introducing qualifying examinations at the end of the first year has been under consideration. However, it does not seem practical to adopt the policy

until the Act is revised.

Every attempt is being made to secure more satisfactory clinical affiliations for our students. The clinical material is here and the administrators of the hospitals and departments concerned are ready to cooperate, but here, as elsewhere, there has been a dearth of qualified teaching and supervisory personnel and, up to the present, such expansion would not have been educationally sound.

In spite of the fact that more nurses have been graduated during the past years, the number available to maintain a desirable nursing service and to give adequate nursing care is still below our needs. Hospital staffs are not stabilized although there is some improvement. Most hospitals would use more general duty nurses and more qualified personnel for head nurse and supervisory positions, if more nurses would become interested

in what someone has termed "the adventure of bedside nursing." Perhaps there is criticism of the hours of duty, working conditions, etc., in Nova Scotia as elsewhere, but every attempt is being made to improve these and at the same time to convince those interested in institutional nursing that reasonable demands will be met as soon as the staffs are large enough to ensure to the patient the best of nursing care. In view of the expansion of hospital facilities now nearing completion, with their improved teaching departments, and those planned for the near future. Nova Scotia anticipates an even greater demand for general duty nurses and a larger student enrolment.

Here as in the other provinces emphasis is being placed on preventive medicine and all public health departments have increased their personnel. More and more of the industries are employing nurses, some of these being qualified public health nurses. Several Red Cross outpost hospitals have been opened this year to provide nursing care in the more isolated areas of the province where no other hospitals or nursing service are available. These are in the charge of registered nurses who are to be commended for their work in these outlying districts.

The "nursing attendant," as she is designated by members of the R.N.A.N.S., has come in for a considerable share of attention. It is hoped to include these workers under the provision of a Nurse Practice Act; the Legislation Committee is working out the details. In the meantime some of the local registries have decided to enrol any nursing attendant who wishes to take advantage of their facilities, provided she meets certain requirements.

Although there seems to be little tangible evidence of the work that has been done, the fact remains that a real interest is being shown and there is every reason to be optimistic about the future of nursing in Nova Scotia.

LILLIAN A. GRADY

President Registered Nurses' Association of Nova Scotia

Health Problems of an Aging Population

EDWARD HALL, M.D.

It is in the interests of the health and general welfare of our people that we consider at this time the trends of our population and the associated problems with which we, as a nation, are faced. From a study of statistics, which can at times be horribly dull, certain very specific facts may be elicited—facts which are indisputable, facts which can convey a very enlightened message, facts which will permit us to plan accurately and wisely, facts which will shock some, amuse others, leave unmoved those who are insensible to their community obligations, and stir up an added sense of responsibility in those who already have a keen interest in the welfare of their fellowmen.

A few figures must be used in establishing certain facts. Please do not make an effort to remember them, they are only confusing; but simply remember the general trends as indicated by any statistical comparison which I may make.

There are several important factors which influence the age composition of the people, the two main ones being the proportion of births and deaths and the population growth. In 1921, the birth rate in the Province of Ontario was approximately 24 per 1,000, and by 1939 it had fallen to 17 per 1,000. Not only is this decrease to be observed in Ontario but it is significant throughout all the provinces, including the Province of Quebec. The decrease in birth rate in Ontario and Quebec is almost parallel, although the actual birth rate is higher in Quebec than it is in Ontario. This decrease obviously means fewer children and, correspondingly, more adults in our communities. This is the first step in developing old age problems.

One must not forget that though the birth rate is decreasing, there is a vast improvement in infant mortality. In 1921, approximately 83 infants died for every 1,000 live births, whereas in 1942 only 40 infants died for every 1,000 live births. Better medical care, pre- and post-natal examination, control of infectious diseases, higher standards of living, and better education in health matters, all have been important contributing factors in more than halving infant mortality in those twenty years. Simultaneously. these same factors have been responsible for slashing maternal mortality from 58 childbirth deaths per 10,000 live births in 1926, to 23 per 10,000 live births in 1942. But let us remember this wonderful saving of mothers at childbirth adds to our adult population now as it did not do twenty-five or fifty or a hundred years ago.

We have, all of us, more or less glibly talked about people living longer now than they used to live. Here are a few facts: read them and then forget them! In 1741, the expected length of life in civilized European countries, including the British Isles, was 30 years! No wonder they had to pack a lot of fun into a few years in those "good old days." By 1841, the life expectancy had risen to 40, by 1891 to 44, by 1921 to 55 and, in 1941, to 63 for males and 65 for females. Control of diphtheria, typhoid, smallpox, tuberculosis, enteritis, and other communicable diseases; better medical care, including better diagnosis; better education; better working conditions, including the abolition of child labor; better nutrition, hygiene, and sanitation, have been responsible for this increased life expectancy. Through such control, too, there has been produced a modification of our population which influences not only the whole picture of health and disease but the whole structure of society.

With all of these factors working to increase the life expectancy of our peoples and with the decreasing birth

AUGUST, 1947

rate, it is obvious that, as each year passes, more and more of our population must pass into the older adult age group and, in fact, that is exactly what is happening. In 1897, fifty years ago, 8.5 per cent of the population was over the age of 60. By 1921, 9.2 per cent was over 60; by 1941, 12 per cent was over 60; and by 1961. almost 14 per cent of our population will be 60 years of age or older. These are significant figures and should make us pause and consider if our planning has taken cognizance of these facts. Nothing can decrease the ultimate death rate; factors mentioned simply delay the inevitable, but in doing so our population gets older.

As our population gets older many new economic, social, cultural, and medical problems arise which are not being faced with the degree of energy which they warrant and ultimately must receive.

With fewer children in our families, more outside facilities for pleasure and the progressively increased cost of living, large homes are becoming obsolete. Small homes and apartments are the rule in urban centres, with large homes the exception even in rural areas. It becomes, therefore, increasingly difficult in small homes or apartments to provide space, facilities, or the care necessary to look after the sick, the convalescent, or the aged in poor health.

The great and increasing demand for social security legislation indicates not only a desire for protection but a fear of not being able to support oneself in older age. The noted success of sickness and hospitalization plans, whether sponsored by government, insurance companies, or by any other agency, indicates a realization on the part of the public that health protection is important and can be paid for on the prepaid low-cost instalment plan. It indicates, too, a fear of the "calamity" illness which can, so quickly, completely wipe out a family's savings and even put them in debt for years. It indicates also, as previously intimated, an acceptance of the idea that the small home or apartment is no place in which to care for a really sick person, the maternity case, or the dying cancer patient, particularly if young children are in the household. What can be worse than for young children and a parent, in a four-room house, week after week, watching and caring for the complete and helpless deterioration of the other parent suffering and dying from cancer or paralysis following a cerebral accident?

In this new country of ours, with the advantages of tremendous resources and skills, many new industries, requiring new techniques, are springing into existence. These new industries, in general, require young people in their employment. older industries which are declining in importance and being pushed aside by the new industries will be found to be employing older people—people who have been in their employment for many years. As these older industries and trades decline a new problem arises, that of the increased numbers of workers in the older age group relative to the numbers of vounger workers. It has been estimated that by 1975, which is less than thirty years from now, an increase of only 6 per cent in the number of workers between 20 and 44 years of age can be expected, while an increase of 69 per cent can be expected of workers between 45 and 64 years of age. Therefore, the aging of our population creates conditions affecting the employment of older workers. problem of retaining these people in employment and increasing their adaptability to new techniques and machines must be solved. There are other economic difficulties created by an aging population, but the few which I have touched upon will give you some idea, at least, of the magnitude of the problem.

Besides the economic considerations, one must recognize, too, the cultural problems. It has been stated most adequately that "the vigor and happiness in old rests upon the foundation of good health and intellectual vitality in youth." The whole problem of education and training of the youth, and continuing or adult education, with all the implications of the development of the mind and the body, associated in the end with character, wisdom, knowledge, and judgment, is implied in the above quotation. True pleasure and happiness should not be denied our people; a good philosophy can be developed by everyone, a warped philosophy only by an unhappy individual

There is one further problem which I would like to discuss as it is part of the picture of an aging population. We have in Canada approximately 124,000 hospital beds of which about 52,500 are general hospital beds, provided essentially for acute general hospital cases. One frequently hears complaints about the shortage of hospital beds and the long waitinglists of patients for admission. You should, therefore, be interested in just a few more figures, and then, as before, forget them. Taking the result of a 1936 U.S. survey of the "number of days of disability per person observed per year," (how complicated that sounds!), and dividing cases into acute and chronic, we find that, for those in the age group of 25 to 65, there is an average of 2.2 days of disability per year in the "acute" class and 8.4 in the "chronic" class. For those in the age group of 65 and over, we find 2.7 in the "acute" class, not very much greater than in the younger group, but in the "chronic" class we find 33. Compare, then, 8.4 with 33 and you have the significant fact.

Closer home, a survey conducted by members of the University of Western Ontario staff this year revealed that in all western Ontario general hospitals, 33.8 per cent of all patients, male and female, were over the age of sixty. The diagnoses, with respect to the patients over sixty,

were as follows:

	Per un!
Cardiovascular — renal	17.8
Accidents, in luding fractures	15 1
Cancer	13.7
Pneumonia and influenza	1 3 7
Prostate and bladder	9.6
Hernia and obstruction	8 2

Diabetes	6.8
Arthritis	4.1
Gall bladder	2.7
All others	8 3

The amount of chronic disease in those over sixty is seven times greater than in those under sixty. It may be of interest to you, and I think it should be, to know that, in Ontario alone, the number of patients in mental hospitals has increased from 10,488 in 1931, to 15,073 in 1945, a ratio of 376 per 100,000 of population and still the mental hospitals are crowded. Mental illness is not mental The vast problem of mental disease is perhaps the most baffling in the entire field of health. Mention of mental health would have no place in this article if it were not for the fact that of all first admissions to these mental hospitals in 1945, 29 per cent were over the age of sixty. So once again, we have a demonstration of the effects of the aging problem since most of these patients were admitted on the basis of mental illness resulting from arteriosclerotic changes. and from family situations—the end result of the social problem of the "unwanted" old folks. There is a vital need for extensive and uniform mental health surveys in our country.

In our survey, with approximately four thousand general hospital beds in western Ontario providing 1,460,000 hospital day beds, 511,000 were occupied by those patients over sixty. I am not for a moment saving, or even thinking, that we should not provide hospital beds for ill people over sixty years of age, but I do think, and I state emphatically, that chronic cases are using up an inordinately high percentage of the beds in our general hospitals which were built and equipped, at high cost, for the care of acute general hospital cases. Operating-rooms and equipment, x-ray and radium therapy equipment, emergency quarters, plaster rooms, anesthetic equipment, diet kitchens, laboratories, and all of those other services which are required for a general hospital, and the highly qualified staffs which must be available, make a general hospital an expensive

concern to operate. Most of these facilities are not required in a hospital for chronic or convalescent patients, particularly if such hospitals are operated near a general hospital where operative, x-ray, and other facilities are available. The costs of a convalescent hospital are, therefore, about one-third of those for a general hospital.

If we take cognizance of facts, our communities would be building not more and bigger general hospitals at approximately \$10,000 per bed, but more and more hospitals for convales-

cent and chronic patients at about \$3,000 per bed. Such hospitals could be built to advantage, not in the centre of a smoke-filled, noisy city or town, but somewhere nearby where green fields, a stream, a river or a lake, trees and flowers, and fresh air and sunshine would combine with good medical care to promote recovery, restore health, and provide some degree of happiness.

Our population is getting older. The conservation of all of Canada's resources, human as well as natural, is a matter of prime importance.

Chronic Illness

SARAH B. GELBACH, R.N., B.S.

A GING IS A PART of living and the nurse has much to do in educating the family to a kindly recognition of this group. Chronic illness is an important factor as a cause of dependency. Economic loss as well as a feeling of uselessness causes more heartache than the chronic diseases themselves.

From 1910 to 1940 the number of persons over forty-five years of age increased from 17 per cent of the total population to 26.5 per cent. The present estimates are that, by 1970. more than half of the population will be over forty-five years of age, and that each working hundred of the population will have to carry fortyfive persons over sixty-five years of age, if these people have not saved enough money to care for themselves. This increase in the span of life increases the number of persons subject to chronic diseases, a problem so important from a medical standpoint as to have given rise to a new specialty geriatrics.

It is the desire and aim of hospital administrators to provide the sufferers from chronic medical, surgical, and neurological ailments with improved and scientific care, and to conduct investigation if the field of

chronic diseases. Unfortunately, it is the exceptional nurse who is interested in and challenged by the chronic patient. An accurate picture of the trends in nursing is shown when recently graduated nurses reveal they have not had the thrill of nursing a patient through a pneumonia crisis, due to developments in chemotherapy. Real nursing is not expressed through the practice of artistic procedures and relationship but has always been made known through love, sympathy, knowledge, culture, and ideals. The better nurse is that one who has a real feeling for philosophy. A nurse-in-training must not get the viewpoint of simply administering to her patients without knowing why she does the various treatments. There must be a desire to learn. The nurse in the field of chronic diseases, which is a much bigger field than acute nursing, must have humor, patience, ability, and quantities of imagination.

Most people are reasonably patient with the lame, the blind, and the halt. We will have to teach them to be patient with those who are sick with a long-term disease also. Chronic illness is increasing and is with us to stay. The care of the chronically ill

is a responsibility of the public.

The confusion of chronic disease and senescence leads to neglect and maltreatment of the chronic sick just as does the concept of incurability. True aging and gradual senile decay may become noticeable after seventy years of age. Persons between their fiftieth and seventieth year, who are disabled and infirm, should be regarded as sick, not as suffering from the decrepitude of old age. In old people, there is a gradual wearing out, an enfeeblement of their organs and tissues which are experiencing a slow progressive decline. Within these limits, they may have no serious organic defect, but are no longer strong enough to carry on unaided.

However, 15 per cent of chronic disease occurs below the 16-year age group when we find such conditions as rheumatic fever, which affects 10 per cent of the population, rheumatoid arthritis, osteomyelitis, poliomyelitis, and tuberculosis, particularly the bovine type, pulmonary tuberculosis, diabetes mellitus, and chronic blood diseases such as syphilis, pernicious

anemia, etc.

If we agree that existing facilities for the care of the chronically ill are inadequate, a practical program must look forward to determine the future needs. Institutions with a sound program have given careful and serious consideration to the following fundamentals:

- Relative distribution of responsibility between voluntary, philanthropic, and official authorities.
- 2. Responsibility of the government for the care of the indigent.
- 3. Desirable size and location of institu-
- 4. The extent to which beds are needed in hospitals and treatment centres as distinct from homes for patients who cannot profit from treatment but need continual personal and nursing care.
- 5. The most satisfactory methods of financing care for patients unable to pay in whole or in part.
- The most effective means of maintaining adequate standards of care—i.e., through licensing laws, periodic inspection by provincial and local authorities.

Prevention of the chronic diseases is the first concern. It should begin with adequate education in personal hygiene, right living, and suitable diet. It includes an annual health examination which may reveal a focus of infection which can be removed before the secondary effect results in disability.

The medical profession has realized the need for institutions for those of the chronically ill, convalescent, and incurable who cannot be cared for at home. It is not a matter of debate whether such facilities should be provided as separate institutions or as wings on an acute disease hospital. It is essential that these be unattached units. The way to successful treatment lies in the examining and screening of patients in a special diagnostic clinic and segregating them for

homes for the aged.

Staff must be adequately prepared to meet the needs of this field. Nursing the chronically ill requires a sensible balance between the requirements of the brain and the requirements of the heart. There is a place here for the nurse aides but the work should be planned and organized by a fully qualified nurse. Only in that way can the best care for the chronic patients be guaranteed.

care in the chronic disease units or

BIRLIOGRAPHA

- 1. Boas, Ernst, D., M.D. A Community Program for the Care of the Chronic Sick. Hospitals. Feb. 1936, 10:18.
- 2. Gelbach, Sarah B. Chronics Need Skillful Nursing. Trained Nurse and Hospital Review. CXVI: 2, Feb. 1946, pp. 119-121.
- 3. Gelbach, Sarah B. Nursing Care of our Aged. American Journal of Nursing. Vol. 43, Dec. 1943.
- 4. Henry, C. E. The Medical Care of the Aged Patient. J. Missouri, M.A. Vol. 37, Nov. 1940, pp. 471-472.
- Jarrett, Mary C. Chronic Illness in New York City. Published for the Welfare Council of N.Y.C. by Columbia University Press, 1933.
- 6. McCay, C. M. Diet and Aging. J. Am. Dietet. A. Vol. 7, June-July 1941, pp. 540-545.
- 7. Musser, J. H. The Aging Heart. *Illinois M.J.* Vol. 79, June 1941, pp. 510-516.

The Care of the Chronically III

EDITH ROWE JANE LEWARNE JESSIE WILSON

DURING THE past twenty years it has become increasingly apparent that the sociological changes due to increased length of life and the change in population from rural to urban was rapidly reaching a point where action was necessary in order to care adequately for the chronically ill. That this point has now been reached is evidenced by the prominence given it in the press and, more concretely, by the building and expansion programs being undertaken.

The classification of the chronically ill made by Mr. Donald M. Cox, secretary and manager of the Winnipeg Municipal Hospitals, in the April, 1946, issue of *The Canadian Hospital*, helps to clarify our thinking in this

connection:

1. Those requiring intensive medical and nursing care for both diagnosis and treatment.

Those requiring skilled nursing and medical care but relatively little in the way of specialized treatments.

3. Those who suffer from permanent disabilities and who require considerable assistance and supervision but relatively little

medical and nursing care.

When the chronically ill are divided into these three classifications several questions come at once to one's mind. Should they be part of or closely associated with a general hospital in order to give, most advantageously, intensive medical and nursing care for treatment and diagnosis? Should they be in a hospital in the country where there is fresh air and sunshine? For the custodial group, should they be in hospital at all or is there not a more suitable setting for many of them where an educational program could be carried on directed toward personal and financial independence?

There will be differences of opinion as to how the chronically ill can best be cared for but few will dispute the fact that they deserve the very best

type of care.

Hospitals for continued care should

be bright and cheerful. Color therapy should be employed to take away from the monotony of dull walls. Colors have a definite effect upon the mental and physical state of everyone. Colors correctly used cheer our spirits and increase our sense of well-being; incorrectly used colors depress us. If tones and tints affect those who are well, how much more do they affect those who are forced to stay in one room for long periods of time?

There are many small details which help to make a hospital of this type satisfactory. Floors which are warm, not too highly polished, and easily cleaned are helpful. Small wards of not more than four beds and many single rooms add to the comfort of Gav hangings are much appreciated, as are low windows where the street or garden may be seen. Good pictures in the day-rooms and corridors add interest for both patients and staff. Balconies, solariums, and a garden are thoroughly enjoyed. Bathrooms should be easily accessible, with the basins placed low enough so that patients in wheel-chairs may be able to care for themselves. Handrails placed in strategic positions and low bathtubs placed well out from the wall are a few of the details which help facilitate care.

In the care of the chronically ill many supportive services are necessary. Dental and oculist services are essential and physiotherapy and occupational therapy form an invaluable part of patient care. These necessitate treatment rooms, work-

rooms, and an auditorium.

The nursing care of the chronically ill has been described as the acid test of nursing skill. Certainly their nursing care requires all the resources of a well-integrated personality as well as those of a skilful nurse, for here we are apt to find patients who are discouraged over a long illness, fearful, introverted, and demanding.

Vol. 43, No. 8

INTENSIVE MEDICAL CARE FOR BOTH DIAGNOSIS AND TREATMENT

There is little difference in the nursing care required by the first two groups. In both, we might expect to find patients with cardiac disease, anemia, arthritis, carcinoma, or diabetes. Such patients require the same skilled nursing care as those who are acutely ill and, in addition, vigilance in detecting and reporting symptoms which might easily be overlooked in a person who is chronically ill, symptoms thought to be "the same old complaint."

When possible, getting patients out of bed daily seems particularly important. It helps to keep their joints flexible; it tires them so that they sleep better at night; they are able to do more for themselves; it stimulates them mentally; they seem less susceptible to respiratory infections.

Those who have to spend long months or years in bed require extremely good care of the skin with special attention to pressure points. Diapers can be most useful for incontinent patients who are turned, washed, and changed every three or four hours. Nurses should be encouraged not to put pads inside diapers as these hold the urine and are apt to irritate the tissues.

The prevention of bed sores is an unending struggle. Reddened areas must be massaged thoroughly, washed with soap and water, and well dried. Frequent changing and proper turning of patients is the greatest aid in avoiding bed sores. When an area is broken down the treatment varies, depending on the site and severity of the abrasion. Considerable success with deep ulcers has been achieved by the use of sulpha or penicillin.

The diet of the chronically ill is a very important part of treatment. Surely no other type of patient is more deserving of good food than these long-term patients who may develop serious nutritional deficiencies if their diet is inadequate. Who could possibly appreciate more thoroughly receiving attractive, hot, well-cooked meals, when the appetite is apt to be jaded and interests, of necessity, have be-

come fewer and fewer? As much as possible, patients should be encouraged to take time to feed themselves. For those patients who have difficulty or who cannot feed themselves the nurses must give the necessary assistance. A good bed-tray of some type is most helpful, and a diningroom is of very great value for uppatients. A soft, bland diet is necessary for some but for the majority a diet which resembles as closely as possible that which one might find in a home is provided. Patients, particularly, enjoy such things as pie, pan-cakes, salads and relishes. The gastric upsets one might expect from the inclusion of such foods in the diet seem to be counteracted by its enjoy-

In a hospital for the chronically ill there are many aged people and this is a whole subject in itself. Characteristically they are forgetful, tend to reminisce and to fabricate. Therefore, the nurse caring for these people should be kind, understanding, and willing to take time to listen sympathetically to their stories. Many are untidy and disinterested in their appearance so it becomes necessary to encourage a pride in personal appearance. They are often lonely and need to be encouraged to keep in touch with friends by visits or correspondence. Former interests and hobbies should be encouraged and the development of new ones fostered. Rules and regulations should be kept at a minimum, for these are persons of many years of habit who are apt to resist coercion imposed by younger people. Recreation suited to their limited powers of concentration is desirable. Perpetual idleness leads them to resort unconsciously neurotic devices exploiting a genuine il'ness or inventing one for sympathy.

PERMANENT DISABILITIES ALLDING SUPERVISION AND ASSISTANCE

Among the disabled we find two groups in the hospital for the chronically ill: Those who have been handicapped for many years and who have more or less become adjusted to their condition; those who have been transferred from a general hospital and are now facing the prospect of continuous hospitalization. In either group there are aged and young. The older ones have various diseases of the nervous system, paralysis due to other causes, cardiac conditions, or arthritis. The younger ones are usually hospitalized because of cerebral palsy, traumatic

paralysis, or poliomyelitis.

It is heart-breaking to watch such patients slowly lose courage and hope, wondering why they have to live. They must be provided with something to make the day worth living through. They must be helped to create a place for themselves in the scheme of things. There must be a willingness to struggle patiently with nature in order to win even a partial cure. The term "incurable" must never be mentioned. What was once considered incurable may now be cured. Think of the difference in the prospect for paraplegics after World War I and World War II. There is need for a change of perspective on the part of the community, the family, and the medical and nursing professions in regard to chronic disease.

It is impossible to avoid entirely an atmosphere of institutionalism but much can be done to make a hospital friendly in spite of its size. A sheltered workshop would seem ideal for the physically handicapped where they would be away from those acutely ill, and from the senile and arteriosclerotic patients who so far do not seem to belong anywhere. Here they might be trained to become happy, self-supporting citizens.

The permanently disabled have time and energy to study and appreciate hospital facilities. Some of the details which they most appreciate are: Privacy for treatment through the use of cubicle curtains; the security of having a call-light; sufficient storage space in roomy bedside tables; bannisters and hand-rails where necessary; adequate lighting for reading; good meals served attractively with reasonable catering to individual tastes; liberal visiting hours; opportunity for religious observances; a united cheerful staff; attention to

dental needs, care of the eyes; library service; an occupational therapy department, in fact anything which emphasizes capabilities rather than disabilities. This attention to the psychological reactions of the patient is most important, for flabbiness of the spirit can be as serious as flabbiness of the body. A handicapped person should be treated as a normal human being. He must not be babied, nor must be urged to do things which are physically impossible for him, but everything he can do should be required of him. The handicapped should be expected to observe the conventions and emotional restraints expected of normal people. To make allowance for rude or childish behavior simply on the basis of the handicap is a great mistake. When temper tantrums do occur the removal of the person to a single room where there is no audience seems to be most effective.

These patients, as do all patients, need someone to talk with, to discuss their interests and their problems. In a hospital providing continued care, the nurse has the advantage over the nurse in a general hospital who, particularly in these days, has little time to talk to anyone. The former gets a second chance to do many things she has always wanted to do for which she never had time. There is some excuse for strict attention to business in general hospitals, but in hospitals for the chronically ill the content of the "business" changes. Here emphasis should be placed on adding "life to their years" not just "years to their life.'

One cannot leave the discussion of chronic illness without mentioning its prevention. While certain psychological changes do take place with age, it is wrong to assume that disease is the unavoidable accompaniment of age. Many people, due either to ignorance or to lack of interest, do not make the necessary effort to prevent it. Periodic examinations, early treatment of minor ailments, and the observance of the known laws of hygiene would do much to prevent chronic illness.

The Student Nurse and Chronic Illness

ANNE BERNICE CONNOR

THE problem of the care of the chronically ill and aged is one which was accentuated by the war years. It is accompanied by considerable waste of medical facilities and fundamentally irregular handling of the sick. Long lines of chronically ill patients occupy the benches of our out-patient departments week after week. The lack of humanity in bringing these people back and forth from their homes is incredible but sometimes necessary with the present set-up, because there is no adequate visiting physician service to the patients' They wait sometimes for weeks to be placed in a chronic illness institution which is always overcrowded and, in many cases, unsuited to their needs. The group of sufferers classed under this heading is very large and familiar to most of us. They include those who need little or no medical care, and those who require the best and most intensive care that can be given only in a modern hospital.

Providing satisfactory nursing service for these patients is a major problem. Chronic disease patients occupy many of the beds in our busiest institutions. Elderly patients fret away the long months in fracture beds; some become home problems because they grow incontinent; some are sliding downhill mentally as well as physically. Crowded old people's homes are ill equipped to care for persons needing practical nursing care and occasional medical supervision. The few nursing homes are not reasonably priced or publicly subsidized. Beds for convalescents have not even been considered in many community health programs and, in the face of this, the old people stay on, sweetly or whimperingly, month after tedious month.

Experience has shown that special chronic disease hospitals cannot satisfactorily conduct nursing schools and,

as chronic disease patients are not generally cared for in other hospitals, most nurses have not received the efficient training they need, nor have the nursing needs of the chronic patient been impressed upon them. There is opportunity for the employment of all the arts and skills which a nurse may acquire in the relief of pain and suffering as well as to give the routine care which may be required. Resourcefulness and ingenuity have opportunity for very full development in such nursing. This manifests itself as the disease or age progresses and the various demands increase. Ingenious devices and pieces of equipment that never came out of a textbook are evolved from the nurse's brain and take their place as an important part, of the environment. From a psychological standpoint, there is no field of nursing in which adequate training could be of greater value.

Nurses who care for the chronically ill should be intelligent observers, able to tell the difference between real and fancied illness. They must co-operate with the occupational therapist, the librarian, and others to see that the entire treatment is co-ordinated, to help maintain the patient's morale. They must possess real tact and firmness and, above all, an unlimited capacity for friendliness and kindness. It is hoped that some stress will be given in the schools of nursing to the needs and qualifications for chronic disease nursing.

The objectives which we have before us for achievement in this field include:

1. To promote the comfort and effectiveness of the chronically ill patient by the practice of good nursing based on a better knowledge of the nature of chronic disease and its effect on the patient and his family.

To learn how to promote health and prevent conditions which result in chronic illness. There is now and the future will bring a greater demand for nurses in this field. Since demands for nursing in the community have a direct bearing upon what should be included in the curriculum in order to prepare the nurses for general service, it is time that this type of training was included in our regular programs. This service, when added to the services now provided, should contain the following:

 Instruction in nursing general and specific chronic diseases. This should be both classroom and clinical instruction.

2. The history of geriatrics which would indicate the significance of the increasing life-span, premature senility, normal anatomic and personality changes expected in senescence, including the social and economic aspects.

3. The study of psychological problems involved in nursing chronically ill patients.

4. Methods of improving the patient's morale.

Occupational therapy which will foster a sense of usefulness and service in the aged.

A study of the resources available for recreation and occupational therapy in the community.

This outline of objectives provides educational subject matter which, with carefully planned guidance of graduate nurses, would permit rapid advances along these lines.

There is much of value from an educational standpoint in having a service for the aged and the chronically ill within the general hospital. Even better would be an affiliation with a hospital devoted entirely to the care

of these patients.

With a systematic and well-organized teaching program, the educational value to the student can be Definite training in the limitless. methods of thinking, observing, and solving problems is provided. gentler, more thoughtful, and more complete type of manual skill and habit of work may be developed. Ideals, attitudes, appreciations, and character values may be fostered, through such a course, that would be invaluable and encouraging to better nursing care for any and all types of patients. Enlarging upon these points,

we might say, for instance, that, in the observance of symptoms, the most serious responsibility rests upon the nurse for frequently the patient cannot even speak for himself. In a hundred and one ways the chronically ill patient needs skilled watchfulness to protect him from conditions to which the patient in hospital for only a few weeks is never exposed. The gradual wearing down of resistance, making him susceptible to acute infection; the pressure of constant pain, which must be alleviated by medication with the resultant danger of habit formation; and countless other examples all suggest the necessity for skilled educated workers. Small victories are won over the enemy by preservation of healthy tissues and beating back "trophic lesions" or "pressure sores," as in the case of the helpless paralytic; securing moderate comfort for the arthritic by devising methods whereby movement is reduced to a minimum and by which painful joints may be cleansed and tissues kept in a healthy state; the ingenuity required to give a shampoo to a patient unable to move; the administration of medication, the carrying-out of treatments, the necessary surgical dressings, frequently present difficulties with patients of this type. Here again all the skill of the nurse may be directed to a successful adaptation of her knowledge. The careful planning of the diet necessitates understanding not only of nutrition but of the individual psychology of the patient, his background of race, society, and habit. It must not only nourish an undermined system, but must also be given under suitable conditions, not in haste, at a time when no physical or mental distress is present.

The nurse must have an insight into the spiritual as well as the psychological and physical needs of her patient. To know that one is on the last lap of the road is, to many, a great sadness which is oftentimes relieved by the quiet acceptance and determination to make the best of it in the philosophy of the nurse. Frequently the nurse in her ministrations is "ministered unto" by these patients

and is given to see how truly great a hero a human being can be in the midst of unspeakable suffering.

One outstanding thing that the student nurse learns while in this service is to teach the patient the art of living in bed. She does this through providing suitable activities, encouraging a hobby, interest or talent; broadening the horizon of the patient through reading material; teaching him carefulness while being careful herself; last, but not least, fortifying the patient with faith and the "will to live," in the belief that life, though handicapped, can be worthwhile.

Behaviour problems due to disposition changes come with old age and chronic diseases. These must be met with stabilization rather than restraint. The best tools for the purpose are persuasion and companionship. The patient's life is a lonely existence at best and must be brightened by cheerful neighbors and a staff with a sense of humor. Freedom, independence, privacy, quiet, and some sort of work will tend to make

these people more happy.

The program of clinical instruction for student nurses in chronic diseases should consider, so far as possible, the capacity, needs, and difficulties in handling these patients. Assignments should be arranged in such a way as to provide for progressive experience and should be planned to develop and integrate theoretically practical and social aspects of nursing. It is believed that students would benefit most by having this form of affiliation during the last half of the second or in the third year of her training. During the first year she is being oriented to a new way of life and to nursing in general. She should have had junior surgery and medicine for a background in the care of the chronically ill and she should also have had some experience in a private or semi-private ward to get an understanding of contrasting cultural backgrounds of patients. She should have had some experience in the diet kitchen. Having her experience with the chronically ill and aged after these other experiences gives a logical order to

the learning process by using knowledge and skill that the student already has and allowing her to benefit from the program at a time when she is ready for this progress. The desirable length of experience in this field should be from six weeks to two months and the work program progressive in educational value and responsibility.

The patient assignment method affords the opportunity of nursing a patient as a complete whole. The student learns to study the patient, to plan for the nursing care to meet changing needs, to relate mental attitudes to physical conditions, to realize the opportunity for social study and health teaching, to assume responsibility for the ill patient. This method simplifies the problem of supervision and evaluation of nursing care. In a hospital for chronic diseases the ratio should be one member of the nursing personnel to every three and one-half patients requiring nursing care. In the custodial section of such a hospital, which includes the aged who are well, one member to every six or seven patients is usual. Nursing personnel includes all persons who actually serve the patient—graduate nurse. student, aides, assistants, and orderlies. Of necessity, allowance must be made for fairly wide variations owing to changes in the nursing load as it is affected by the degree and number of convalescents. The patient assignment method is the most efficient means of stabilizing these variations.

In their declining years some people thoroughly enjoy living. Even though more or less disabled physically, they may be useful and influential. It is worthwhile to search for this secret before age gets the better of us. For those who are unfortunate enough not to have discovered it, the nurse of the future will be the one to whom they turn. The aged should be given all the assurance possible when the outlook is grave. Life means nothing when hope is gone and even old people may shrink from death.

Individual patients may present so few signs that nurses forget that they are ill. Their tendency to answer such patients sharply is one of the liabilities connected with their presence on the wards of a general hospital. Chronic illness is not necessarily associated with old age, although the older the patient the more complicated his mental state and the slower his return to health. The chronically ill patient of yesterday was always a

bit forgotten. Let us now prepare the nurse for the future according to the needs of these patients and not make the mistake of thinking that chronically ill patients are limited to those in advanced stages of senility, and cripples who do not need expert medical care and cannot benefit from it.

Occupational Therapy for the Chronically III

MURIEL F. DRIVER, O.T., REG.

THE care of the chronically ill entails more than routine nursing service. Both the physician and nurse will be quick to recognize the various psychological problems which may result from long periods of hospitaliza-Both as a prophylactic and curative measure, occupational therapy is included when treatment is prescribed for this type of patient. It provides many mental and physical benefits and at the same time adds a note of normalcy to hospital life. Routine nursing care occupies certain periods of each day and the importance of this care cannot be minimized. However, there remain long idle hours in which the patient may do one of two things. His mind may dwell on his discomforts, both real and imaginary, and so undo much of the good work of his physician and nurses. He can direct his attention to an activity, mental or physical, selected and guided by the occupational therapist.

The therapist is, therefore, part of the team of workers whose aim it is to make the patient as comfortable and as happy as is possible within the hospital. It is not her desire to work as a separate entity, but rather to work in complete co-operation with the physician, nurses, and whoever else is concerned with the patient's welfare. If the patient is to receive full benefit of this treatment the therapist must have a sound knowledge of her patient's condition. This can be gained in three ways. First, by making rounds with the physician and nurse; second, by having access to the patient's chart; and, third, by frequent verbal discussion with the nurse. In turn, the other team members must also be informed as to what type of occupational therapy the patient is receiving. At Runnymede Hospital, Toronto, occupational therapy progress notes are recorded monthly on the patient's chart. The record does not consist merely of a report on the activity prescribed but includes the degree of co-operation, concentration ability, enthusiasm, and any favorable or unfavorable reaction to this form of treatment.

The occupation chosen by the therapist is merely a means to an end, serving as a "thermometer" on which can be read a variety of data concerning the patient's mental and physical condition. Poor work may indicate lack of manual skill, lack of concentration, poor vision, disinterest, loss of energy, poor co-ordination, or mental retardation. When planning the occupation program for a patient it is necessary to assess his capabilities and provide activities in which he can participate with pleasure and success. Frequently, his physical limitations will necessitate the adaptation of some equipment or tool, simplification of a design or technique, and careful selection of material. If the nurse understands the therapist's aim she can be most helpful by displaying interest in the project. A few words of encouragement from his nurse mean a great deal to the patient.

It is difficult to separate the mental and physical aspects of treatment. Seldom do we see the patient progress physically without a corresponding mental improvement. If the activity chosen for him serves to increase joint mobility, the patient's mental outlook brightens as he finds himself capable of increased activity. those whose activities must be restricted, occupational therapy provides a controlled outlet for their energies. By encouraging them to centre their attention upon a craft project, we minimize their inclination to worry about themselves or their neighbors and we find them adjusting better to hospital life.

Mrs. X is a woman of seventy, confined to bed with a cardiac condition and diabetes mellitus. Before occupational therapy was prescribed, she lay in bed taking slight interest in the world about her. She was subject to frequent crying spells and talked continually of her physical discomforts. Although it was a month after the initial effort before the therapist was able to catch and hold the patient's interest, the gradual improvement has been very marked. Now we see her taking a most enthusiastic pleasure in her various projects and an active interest in her surroundings. She had never done any needlework before. Being lefthanded, she felt such work was beyond her capabilities. Her first piece of simple embroidery on monk's-cloth was far from perfect but the bright colors gave a pleasing effect. Encouraged by her physician, nurses, and therapist she strove to improve this simple technique. In the first glow of achievement, Mrs. X was inclined to work too hard, tiring quickly. Since then she has learned to work more slowly. She began to experience again the spirit of competition, asking for some knitting like her neighbors. Here again her first efforts left room for improvement, which in due course was achieved. On one or two occasions, misunderstanding directions, she became emotionally upset over quite minor errors in her work. Gradually she is learning not to fret over such things. Usually this patient has two projects upon which to work. This means that if she finishes one before the therapist's next visit she has the second project to turn to. On other occasions this second project provides the change which is as good as a rest.

Mrs. X is still confined to bed but is in better mental and physical health. She displays a bright sense of humor and considers her sewing to be "medicine." We seldom hear much about her various symptoms. Her need for sedatives has diminished. A recent examination showed her to be wearing faulty spectacles. While waiting for the new glasses, she seemed to be troubled by headaches and dizziness. In an effort to relieve this, occupational therapy was discontinued for almost two weeks. At the end of this time she seemed so restless and unhappy it was deemed advisable to have her resume her activities in spite of poorly fitting spectacles. Since then she has been her usual happy self.

This patient's record shows a clear picture of the value of occupational therapy in treatment of the chronically ill. Our patient no longer has that horrible feeling of complete idleness and uselessness, and yet her new activities in no way interfere with the rest of her treatment program. Rather it would seem that occupational therapy is facilitating her response to the excellent care given by the other members of the hospital team.

Although about 70 per cent of the work of this occupational therapy department is done on the wards, there is a very definite need for the patients' This enables the more workshop. active of the group to participate in the crafts involving noise, space, large equipment, close and continuous supervision, and any degree of mess not suited to ward activities. example, some of the male patients are weaving enthusiasts and by affording them the opportunity to spend the afternoon in the workshop they are able to do much of the setting up of the loom themselves and at the same time can have any assistance necessary when they want it. Later they can take the loom on to the ward to do the actual weaving. This means an increased feeling of independence

and pleasure in personal accomplishment. This workshop offers a sharp contrast to the atmosphere on the ward and we find some of the patients dropping in for a social visit, to see "what is going on." They frequently gather inspiration from seeing other patients at work and from the nnished articles on our "Idea Shelf." During the early or latter part of the workshop period, when the room is emptier, the therapist frequently finds herself able to have a more private talk with an individual patient and so increases her understanding of her patient's problems. Sometimes this knowledge, shared with the nurse, can further benefit the patient.

In viewing the completed projects it can be seen that for the most part the articles are small, simple but attractive and frequently destined for some relative or friend of the patient. Over a period of time some patients show a marked improvement in their technique as their former skills return, co-ordination improves, or pleasure in achievement revives. Wnen preparing projects for this group of patients, it is necessary to do more careful preparation than for a younger and more energetic group. Poor cutting of material can spoil the project and so discourage the patient at the start. At the same time it is essential to induce them to do as much for tnemselves as is possible within the limitations of their disability. It is well to bear in mind that as one grows older the eyesight frequently becomes poorer, manual dexterity may decrease, concentration, endurance, or patience may be diminished. In many instances these factors must be brought into consideration when we observe some of the more obvious manifestations of disease and disability. Another necessary point to consider in selection of the craft and materials is the ability of the patient to regulate wisely his own activity. It is necessary with some patients, such as cardiacs, to ration the materials carefully, leaving just enough to last until the therapist's return the next day. In some instances the quantity of material issued must coincide with the length of time deemed advisable for the patient to be occupied at one time. Still further consideration must be given to patients' tastes. Work that is familiar or that is guided by an awareness of the appeal of some of the more old-fashioned fads is usually more successful than if the therapist endeavors to impose more up-to-date ideas. This does not mean that the project need be unsightly or useless, or that the therapist should not be conscious of the value of variety. Rather it is essential to remember that the patient must be interested in his occupation if treatment is to be of real value.

In an effort to leave the control of "dosage" in the therapist's hands, still further co-operation must be obtained from the rest of the staff. They are expected to consult the therapist rather than the patient if they wish to obtain any of the finished articles, even if they supply their own material. This eliminates the possibility of the patients, who are capable of creating attractive articles, suffering ill-effects from undertaking too much.

This brings us to the question of an annual sale of work within the hospital. The advantage of such a sale is that the hospital disposes of any accumulation of work and can return the funds for further expenditures on materials. There are disadvantages in sponsoring such a sale because frequently the patients, aware of an approaching deadline, are tempted to be over-ambitious. Since we are presenting occupational therapy as a form of treatment and are striving to concentrate on the patients' welfare, it would seem to be poor policy to be forced to devote the considerable amount of time required in organizing such a sale, time which would be better devoted to the treatment of the patients.

Group projects, such as a hospital newspaper edited by the patients, can be of great interest, not only to the contributors but to the members of the group who are less active. The patients who find it difficult to participate in all the social happenings can

read about them in the newspaper and so feel that they are "keeping up with the times." Naturally such undertakings require tact to prevent some of the misunderstandings that sometimes arise when several people work together on one project, particularly when the participants have a variety

of individual experience.

Although many of the patients have frequent visitors there are many evenings that seem too long. The therapist should arrange a variety of entertainment to fill some of these periods. By using the evenings during which there are no visiting hours the nursing staff is not confronted with too much increased activity and all patients able to attend are free to do so. The selection of entertainment must governed by the volume of sound and the degree of excitement likely to be aroused. The variety of tastes encountered in a group, such as will be found in a hospital of this kind, is bound to be fairly wide. However, the favorite programs seem to be movies, sing-songs, musical evenings of a simple form, and games. Local volunteer organizations can be appealed to to supply one or two programs each month. It is wise to remain in close contact with these groups and guide their selection of entertainment. The games evenings can be organized by the therapist who would rearrange her daytime program to make this feasible. The games should not be too complicated but within the capabilities of the majority.

When the occupational therapist considers her entire program for the chronically ill she must realize the challenge this group presents. These are not patients to be fitted into neat little mental pigeon-holes and dealt with in a stereotyped manner. Many of them present long histories of illness and hospitalization and there is a strong possibility of psychic trauma resulting from such an abnormal mode of life. It is necessary to be constantly aware of the patient as an individual personality whose importance is in no way lessened because he has been admitted to hospital accompanied by a certificate of incurability. With the younger members of this group the question of re-education arises. What does or will society do to broaden the scope of those capable of some form of remunerative occupation? If society is doing or is going to do something for these patients, the therapist must be ready to make her contribu-From observing the patients under her care the occupational therapist gathers information regarding work habits, reliability, endurance, and general aptitude. She can start the re-education process by bringing her patient to the stage where he is ready for industrial or commercial training. He must first learn the pleasure of accomplishment and the value of sustained effort. Conscious of all the ramifications presented by this field of medicine the occupational therapist finds stimulation and satisfaction in her work.

With UNRRA in Germany

LYLE M. CREEIMAN

BROADER HEALTH PROGRAM

A STHE MOVEMENT of DPs from place to place grew less, and the population of the assembly centres became more or less stationary with the approach of winter, a broader health program was possible. Moreover, having the communities fixed made it easier to establish and to coordinate health and nursing services.

As in any health service in any country, the greatest return for the effort expended resulted from work with mothers and young children. To most of them, any form of health education was quite new, but, as they became convinced that their children would benefit, they were most eager to take advantage of the offers. At the outset expectant

mothers were very reluctant to report for examination but, when it became known that extra milk was available if a card showing regular attendance at the clinic could be produced, and also that material for a layette would be provided free, the majority came to the prenatal clinics. In most assembly centres, the nurse arranged a rest centre to which mothers might return for a few days after discharge from hospital, and before taking the baby back to the crowded communal quarters. During that time the mother had extra rest and was taught how to bathe and care for her baby. The most attractive of all these centres, and the one in which the best teaching was done, was staffed by two conscientious German nurses. The DP mothers showed no hesitation whatever in entrusting the care of their babies to these nurses - why should they, indeed, when the obvious mutual interest was the welfare of the Baby clinics were organized wherever possible, and attendance increased gradually until a very large percentage of the mothers with young babies were coming to receive advice from doctors and nurses. So far as could be determined the infant mortality rate was about 80, which compared very favorably with a recorded rate of 140 in Poland in 1939.

The development of special feedfacilities for children was a chief responsibility of the "Relief Services Personnel," the doctor, the nurse, and the welfare officer. nearly all centres a children's diningroom was established, in which the children had at least one meal a day. Other meals were taken in the living quarters with the rest of the family. Those circumstances made communal lodging and some overcrowding very common. Communal feeding was not common, most of the DPs preferring to obtain their own rations and prepare and eat their meals in their This method was enown rooms. couraged wherever facilities permitted it, as it helped to maintain the family unit. The rations provided permitted only a daily calorie rate of 2,400 which at one time was reduced to 2,000 and, ultimately, slightly lower. There was never an adequate supply of milk. Fresh fruit simply could not be provided, and fresh vegetables, except in season, were very difficult to obtain. great deal of bartering went on between the DPs and the neighboring farmers wherever this was possible. No scientific nutrition studies were made at the outset, but several careful surveys were subsequently conducted to determine the degree of nutritional lack. From the appearance of the children, one would expect that a high percentage suffered from nutritional anemia, but investigation showed that the distribution of frank nutritional disorders was by no means uniform.

One of the outstanding difficulties was the lack of facilities for the diagnosis and treatment of tuberculosis. The incidence of the disease was not determined. It was commonly regarded as high, as a result of the living and working conditions under the Nazis, and it was considered that the overcrowding in the DP camps was conducive to rapid spreading. tually, when a survey was made at Belsen, where it had been expected to find as many as 50 per cent affected, the results were amazingly low; but there is no doubt that a considerable degree of tuberculosis existed. When a case was diagnosed and hospitalization recommended, it was most difficult to persuade the patient to leave his family and go into hospital unless, indeed, he really felt extremely ill. When he did go, his family frequently went with him, and nearly all hospitals had a very great number too many on their books.

The incidence of venereal disease was also unknown, as there was no compulsory examination, and the treatment, due to lack of penicillin, was antiquated and inadequate. Known cases were under treatment for long periods, during which time they occupied much-needed hospital beds.

Except for tuberculosis and venereal diseases, the incidence of communicable disease was relatively low, and was much less than the rates among the German population.

The question of excessive admissions and failure to discharge from hospital convalescents and persons who could not be justified as bed patients presented a difficulty. Many doctors and nurses, whose sympathies were seized by stories of the sufferings of the DPs under German rule, were easily persuaded to allow relatives and friends to remain in hospital with patients and, at one time, the percentage of "patients" hospitalized was three times as great as could be justified on the statistics of bed provision for any ordinary, or indeed any poor, community.

The organization of the assembly centres was a matter of growth by trial and error, but ultimately became quite effective. The assembly centres which operated most efficiently were those in which the UNRRA team director and his staff were able to organize the displaced persons in such a way that their elected leaders did the actual work, leaving to the UNRRA personnel the necessary official contacts with the military authorities and general overall supervision and guidance.

HEALTH COMMITTEES

As a health group, we were slow to make use of DP health committees. Perhaps this was because there were so few trained DP personnel. Many had suffered from so much deterioration of morale, and there were so many things that had to be done immediately as matters of urgency, that it seemed easier — as it always does to do it oneself. However, when there was time to think about developing the health education aspects of the program, committees were formed with very gratifying results. Reference has already been made to the services provided for mothers and children. Much assistance was received from DP health workers. One of them was usually appointed for each camp, or for each block of buildings, and had the duty of visiting every room to check the sanitation and reporting any cases of illness to the UNRRA

nurse, who would then visit and take any necessary action. This method proved very effective because the DP mothers were far less likely to hide sick children from one of their own people than from an outsider. The health worker was often able to explain the nursing service and so allay unnecessary anxiety. She was also able to show the reason for the use of protective foods and medications, and supervise, for instance, the distribution of cod liver oil. Though supplies of this commodity were extremely short and sought after most earnestly by the civilian population outside DP camps, it was hard at the beginning to show the DPs how essential it was that their children should receive what little was available. Many of them, indeed, considered it much more sensible to use cod liver oil as a grease for shoes than for internal consumption!

The activities in the camps, which began as social services of a somewhat scattered nature, ultimately extended to the whole of the internal administration, with a strong empasis upon medical and nursing care and social welfare.

ADMINISTRATIVE STRUCTURE

As previously mentioned, the third point in the UNRRA program was to build up a proper administrative structure. The country was divided for military control into corps districts, eight corps having the area from the Danish border through Schleswig-Holstein, thirty corps extending from Brunswick and Hanover across to Holland and Belgium, and one corps taking in the southwestern remainder of the British Zone of Occupation. Central headquarters, as stated, was at Bad Oyenhausen, and ultimately distributed in several of the less-damaged villages around Minden, Herford, and Bielefeld, particularly in Lubbecke and Bunde

The Zone Director for UNRRA established his headquarters at the beginning of August, 1945, in the village of Spenge, from which it was transferred to Lemgo in the second week of June, 1946. The headquarters

unit of UNRRA was established in close relation to the headquarters unit of the army and, subsequently, to the Control Commission for Germany. Under this UNRRA Zone Headquarters there were three UNRRA district headquarters corresponding to the three army corps mentioned above. In each army corps area there were set up three to six field supervisory headquarters, the number depending on the urgency of the problems, the number and location of assembly centres in the district, and the total number of displaced persons for whom provision had to be made. For each assembly centre there was an UNRRA team and, when the organization was built up in the late autumn of 1945, there were 210 centres for some 600,000 DPs.

At each administrative level there was a chief administrative officer and his administrative staff. The organization of medical, nursing, and social or welfare services — together known as the "Relief Services" -- followed the same pattern. Overall control rested with Zone Headquarters. Since the team was the unit in the field and actually the oldest established service, there was at the outset considerable difficulty in co-ordinating activity. There was some opposition to the appointment of a supervisory nurse at the field level. Field administrative officers could not visualize any function that required the services of a supervisory nurse, while many of the team nurses preferred to carry on in their own way without a supervision that they considered would be "outside interference." Great credit is due to the field supervising nurses for their quiet but determined, and ultimately successful, demonstration of the value of supervision. They were able to distribute and allocate the nursing personnel, drawn from both UNRRA and displaced person groups, to the best advantage. They stimulated and guided the nurses, many of whom were not trained in public health or in the appreciation of a public health program. They developed staff education and an esprit de corps through regular meetings and, in fact, they used all available tools of supervision to encourage the team nurses to provide the best possible nursing service in the interests of the displaced persons and of efficient administration generally. To many of the UNRRA nurses this was an entirely new approach, and they learned from it many principles which it is hoped will be of value to them in the years to come.

UNRRA NURSING TEAMS

When I first arrived in Germany early in July, 1945, the UNRRA nursing staff totalled 104, of whom 19 only, (18 per cent), were of English-speaking nationalities. By the end of November, 1945, recruitment had brought our numbers up to the highest peak attained, 211 of whom 29 per cent were of English-speaking nationalities. Among these were sixteen Canadians and seven American citizens. On the staff there were nurses from twelve different countries. It was a most valuable and interesting experience to observe the differences in professional background displayed, and to try to develop, with such a mixed staff, more or less uniform nursing service and nursing standards. The majority of the non-Englishspeaking nurses had, however, the advantage of being able to speak German, which was the language most commonly used in conversation with the DPs. Nevertheless, it was notable that language was little handicap after a few weeks or months, as the staff very quickly learned a sufficient number of words to ensure understanding.

Looking back on this experience, I think it was probably the team nurse who gained most value from service with UNRRA. It was she who had the satisfaction of doing the real job for the DPs; of having the close contact with them that was so interesting and revealing; and of knowing that her services as a nurse were actually helping to relieve the suffering, or to rehabilitate people who had already suffered and lost so much.

Nursing for UNRRA was not an



A nurses' aide class in Germany

easy task. In addition to good professional qualifications, the nurse had to be a person willing to undergo cheerfully many physical discomforts and to meet many emergencies with calmness and assurance. She had to be able to assess the total needs and to decide which among them was a "priority." In the beginning, there was so much to do that it was certainly a case of doing the most essential things first. It has been mentioned that in the early days many of the DPs were still on the way home. and there was a continuous movement of populations from camp to camp some going out, others coming in; some searching everywhere for friends or relatives; others grouping themselves with those who spoke the same languages or came from the same prov-The first thing the nurse had to do in this changing scene was to find helpers from among the DPs themselves - preferably, although all too rarely, qualified helpers - who would have sufficient stability to undertake nursing aide work and to "stay put." Usually there were some women or young girls who had had some experience that was valuable, and these were particularly useful in the sick bays that were set up in every centre.

NURSE AIDE TRAINING

As it was an UNRRA objective to help people to help themselves, it was in order that DP personnel should be utilized to the greatest extent possible in the health program. many assembly centres team nurses organized classes and gave instruction to girls and women who were interested, so that they could be of greater service. In addition to this program, which was very valuable but which was, in the main, uncontrolled and lacking any uniformity in standards. there ultimately grew up from it training courses for nursing aides. These courses were developed by the deputy chief nurse, Miss Norena Mackenzie, also a Canadian, who later on in London was appointed special instructor for the course given to graduate nurses from many countries receiving UNRRA aid

The purposes of our program were to provide extra assistance in the camps and assembly centres and also to encourage young women, who had the required qualifications, to develop an interest in nursing, so that, on return to their home countries, they might enter a school of nursing and become fully qualified nurses.

One of the first centres established was for displaced persons from

the former Baltic States. Five centres were opened for Polish girls, although both groups were sometimes represented. Well-qualified UNRRA nurse-instructors were selected for the teaching and, where necessary. an interpreter was provided. may be mentioned that the fact that instruction had to be given through an interpreter did not seem to lessen its efficiency. In these cases lessons had to be prepared most carefully and the presentation made as simple as possible, with few words and much demonstration. This, together with the necessity of clarifying and crystallizing the ideas of the teacher, usually resulted in better teaching.

By the middle of June, 1946, 192 nurse aides had taken the six weeks' course, and had received a certificate printed in two languages — English and Polish for the Poles, and English and German for all other nationalities. We were careful to state on the certificate that the holder had not taken a course qualifying her as a nurse, while the subjects studied and the time spent on each were listed on the back of the certificate. Although, at the time, we were a little concerned about the necessary shortness of the course, we found on returning home that the training given was much more adequate than that given

today to the majority of so-called nurse aides in many of our Canadian hospitals. The courses established at this time have been continued and, up to the present, well over three hundred girls have attended.

In order to give better preparation to the limited number of DP qualified nurses so that they might take over full responsibility for the nursing service as UNRRA nursing personnel was reduced, a refresher course of ten weeks was planned. Again, the first to be established was one for nurses from the Baltic States. since there was a relatively higher proportion of qualified nurses among this Some difficulty was experienced in finding candidates from among the Poles, who were both qualified professionally and willing and interested enough to take the course. Up to June, 1946, not a sufficient number of Polish candidates had been obtained, but I am informed that later a group was assembled, although not all were fully qualified.

We were very proud that the British Zone was the first zone in which the nursing service organized a training program for nursing aides and refresher courses for the qualified DP nurse group. It was one of the most worthwhile of all the nursing activities.

(to be concluded)

In Memoriam

Katharine Grace Campbell, who for many years was associated with the Edmonton Board of Education as school nurse, died recently in Toronto.

Mrs. Christina Ann Conklin, who graduated from the Winnipeg General Hospital in 1897, passed away recently in Vancouver.

Rowena Hamblin and Jane Warren, student nurses of the Vancouver General Hospital, were among the passengers lost aboard a T.C.A. airliner early in May. A memorial service for them was held at the request of their fellow nurses and associates from the hospital.

Mrs. Carolina Johnson, a former matron of Royal Columbian Hospital, New Westminster, died at the end of April at the age of 80 years.

Mary Martha Kilgour, who graduated from the Toronto General Hospital in 1893, died in Toronto on June 7, 1947. In 1909, Miss Kilgour joined the staff of the Toronto General Hospital as assistant superintendent of nurses. Two years later she was appointed lady superintendent of the Maryland General Hospital, Baltimore, later becoming superintendent of the Home of the Friendless in that city. She retired from active duty in 1931.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Job Analysis

MARION E. BOTSFORD

THROUGHOUT Canada and the United States, during and following the war years, more and more stress has been placed on the value of sound personnel policies in employment of industrial as well as professional workers. In order to make a more scientific approach to personnel practices, such terms as "job descriptions," "job analysis," "job specifications," "job evaluation," etc., have become common usage. Although these terms are not, perhaps, as familiar in Canadian hospitals as in industrial plants, the Institutional Nursing Committee of the Canadian Nurses' Association has recently undertaken a study of job evaluation techniques and is now preparing a guide for the use of such practices within the nursing In order to take advantage of techniques already in use, a nurse observer was asked by the committee to spend some time with Job Analvsts in an industrial institution which has developed a system of job evaluation within its personnel department. The following information regarding the process of job analysis is based principally on the observations made under the direction of these analysts.

Before discussing the details of job analysis it will be necessary to place this process in relation to the whole subject of job evaluation, which is the method of rating a particular job in relation to other jobs within an organization. The purposes of job evaluation include: the determination of an equitable salary

structure; indication of a logical sequence of promotions; assistance of management in proper placements of staff for the various jobs required; and indication of the types of instruction and training which may be of benefit to all employees.

The plan of job evaluation is divided into three distinct phases:

Phase 1—Obtaining all available information about the jobs and writing job descriptions.

Phase 2—Rating the jobs according to a pre-determined scale to establish a "point value" for each job.

Phase 3—Applying a new wage scale to jobs according to "point values" determined in Phase 2.

Our purpose in this article is to discuss Phase 1, or job analysis.

The Washington War Manpower Commission defined "job analysis" as follows:

The process of determining, by observation and study, and reporting pertinent information relating to the nature of a specific job.

It is the determination of the tasks which describe the job and of skills, knowledge, abilities, and responsibilities required of the worker for successful performance and which differentiate the job from all others.

One of the most important aspects of job analysis, and one which should be kept in mind constantly, is the fact that it is an analysis of the job itself and not of the person on the job.

If a job evaluation plan is to

AUGUST, 1947

be a success, in an organization of any size, the detail work should be done by a competent specialist on full-time. Job analysis and evaluation is technical work, and high ability and skill are necessary for a satisfactory result. Trained analysts may be brought into an institution to conduct an analysis, but it has been found of greater value to train personnel for this work from within the organization concerned. Although such persons may not be able to ignore completely the present incumbent on the job, this disadvantage is not serious, particularly as the analysts gain greater understanding of the process; and it is outweighed by a better insight into the various ramifications within the institution. It is suggested also that there should be one or two associate analysts so that two or three independent judgments can be used to reach decisions. These may be drawn from other departments when jobs are to be valued.

In undertaking a job evaluation procedure in any institution, an intensive educational program should be conducted first in order to assure a complete understanding, by executive and staff alike, of the objectives and the results expected of such a program. The complete co-operation of all concerned is a vital requisite for its success, and this is only obtained through an appreciation of

the value of job evaluation.

After the plan has been well publicized and everyone understands its purpose, the analysts select one department in which to commence their work. The first step is to ascertain, as far as possible, the number of job titles in the department. This information is obtained from the department supervisor and may or may not be accurate, as what are considered like jobs, when analyzed, may be found to be quite different, while others may be considered as two different jobs and be actually only one.

An "Individual Job Description Form," with instructions, is then distributed to the personnel of the selected department. This is a questionnaire prepared to meet the needs of the particular institution concerned. When completed it contains the following information: employee's name, payroll title, name and title of immediate supervisor, name and location of department, and the date. Questions regarding the following aspects of the job are to be answered and space is provided for the answers:

Description of daily, weekly, and monthly duties.

List of daily, weekly, monthly, and semiannual records and reports.

List of machines, equipment, and supplies used. Description of unusual equipment and its method of operation.

Proportion of time spent in standing, sitting, walking, lifting, climbing, etc.

Supervision of other employees, indicating nature of supervision and number supervised.

Employee's opinion regarding most complex or difficult part of her work.

Description of conditions present in location and nature of work, such as surrounding, dust, temperature, monotony, working under pressure, lack of co-operation of other departments, etc., which is considered unfavorable or disagreeable.

List of additional duties.

Before distributing these forms it is suggested that the analysts discuss them in detail with the whole staff, and that they stress the point that they are not concerned with personal performance on the job in any way, but solely with the actual duties.

When the questionnaires are completed and returned to the analysts, they are reviewed and then discussed during a personal interview with the

individual employees.

When this form is distributed to the employees, a "Job Classification Questionnaire" is given to the supervisor. A separate form for each job title is necessary. It is suggested that the analyst discuss this form in detail with the supervisor and, if possible, actually complete it during the discussion.

The "Job Classification Questionnaire" contains the following information: payroll title of position, name and title of employees' immediate supervisor, name and location of department, names of employees occupying the position and the date.

The following information regarding the minimum requirements desirable for each position is requested: (It is noted that this does not mean the qualifications of present employees unless these agree with the supervisor's opinion of the minimum requirements.)

Minimum formal education or its equivalent.

Special courses or specialized knowledge.

Previous work experience — its nature, where it can be obtained, and minimum time required to acquire it.

New factors to learn on the job, and length of time required to learn them.

Physical requirements, such as sex, height, strength, eyesight, etc.

Maximum and minimum age requirements.

Undesirable or disagreeable aspects of position.

Number of employees supervised by employee in this position and nature and extent of supervisory responsibility.

Nature and extent of responsibility of job for materials, machine, methods and procedure, records and details, etc.

The most difficult part of the work to teach a new employee.

Positions within the organization from which employees could be promoted to this position.

Higher positions within the organization for which this job should train an employee.

Positions to which the employee could be transferred in the event of reduced activity.

When the above-mentioned forms are completed and returned to the analyst, he is then prepared to write job descriptions. A form is used for this purpose which makes for uniformity of all job descriptions and the material is taken from the employee's and supervisor's questionnaires.

The job descriptions are written under the following headings: job summary, work performed, equipment and supplies used, mental requirements, skill requirements, responsibility, volume and complexity of duties, resourcefulness, working conditions, physical requirements, relations to other jobs.

A card containing a résumé of this material may be prepared for the use of the personnel department. Such cards are useful in conducting interviews with applicants for positions

If outlines of the duties of each job are prepared and kept in each department it facilitates the completion of the employee's and supervisor's questionnaires. On the other hand, if such outlines or manuals are not already in existence, they can be readily compiled by making use of the job descriptions prepared by the job analvst. One manual which was observed in a large business concern used such headings as, "the WHAT of my job," "the WHEN of my job," "the HOW of my job." Complete information regarding the duties required in this job was noted, and the manual was reviewed every six months and revised by the employee when necessary under the guidance of the department supervisor. These job outlines contained in the department increase the efficiency and save time for the present employee and greatly decrease the learning time on the job of a new employee.

Analysis of many job descriptions indicate that there are overlapping elements, many of which can be grouped together under headings indicative of their similarity. In practice it was found necessary to reduce the number of such groupings or factors as far as possible. The five main factors usually employed are: mental requirements, skill requirements, physical requirements, responsibility, working conditions. These may be further broken down into their component parts. For example, skill requirements may be divided into: education, previous experience, training time, versatility, and quality. Each factor is given a number of points and is weighted in relation to the other factors according to the nature of the organization concerned. Each sub-factor is broken down into degrees with an increasing point value for each degree. example, the sub-factor of education may be given ten points and divided into six degrees as follows: (1) Grade

8 (0 points). (2) Grade 10 (2 points). (3) High school graduate (3 points). (4) High school plus business or vocational training (5 points). (5) University graduate (8 points). (6) University plus technical courses (10 points).

The names applied to the various factors can never exactly cover the scope of one factor. For this reason, simple, understandable, and brief definitions of the scope of each factor and sub-factor must be prepared.

When all factors are broken down, clearly defined and weighted as to point value, a rating scale can then be prepared containing this information. This is the yard-stick or measuring device against which all jobs are measured.

To complete the job evaluation process from this point, each job is rated and placed in relation to every other job. This is done by a rating committee which is comprised of the job analysts, one or two people on the job to be rated, a supervisor, and such other people as deemed advisable. All jobs are measured against the rating scale and given a "point value." When all jobs are rated, a new wage scale is applied according to the "point values," and includes a spread to make allowance for personal performance on the job. This is done by a central executive committee.

There are several methods used in evaluating jobs and in conducting a job analysis. All, however, attempt a scientific approach to wage and salary administration, and have proven of value in personnel work.

In applying such methods to nursing, other results might also be expected which should prove helpful. Among them the following could be anticipated and should be worthy of consideration:

- 1. A complete, accurate, and impersonal description of all classes of work within the nursing administration.
- Job information in convenient form for use in making new appointments, promotions and transfers.
- 3. Guidance in rating of employee performance.
- 4. A basis for the preparation of work manuals, thus decreasing the length of the adjustment period for new employees, and increasing the efficiency of present incumbents.
- 5. Assistance to supervisors by familiarizing them with the work expected of their staff.
- 6. Disclosure of unnecessary routine and duplication of effort.
- 7. Provision of a basis for improved organization of nursing personnel and division of authority and responsibility.

At this time of acute shortage of nursing staff, continuous staff changes, and requests for salary adjustments, such a scientific approach to personnel practices should be of considerable value. In industrial and business concerns where job evaluation programs have been carried out and new wages scales put into effect, outstanding results have been obtained in increased efficiency and production, better co-operation, and greatly decreased turn-over in staff. Such results would undoubtedly be of value in the nursing field.

War Memorial Trust Fund

Our pride in the meritorious record of the Canadian nursing sisters is symbolized in the cover picture which depicts the Governor General, Viscount Alexander, pinning the Royal Red Cross on Lieut. (N/S) H. T. Morrill of Fairville, N.B. Tangible evidence of our pride will be found in the donations to the War Memorial Trust Fund for the purchase of libraries of professional books to serve the nurses of the devastated lands. The total is growing slowly but it

needs the combined interest and energy of nurses in all parts of Canada before we will be anywhere near to the original objective of \$32,000. The following figures represent the total donations, to date, by provinces: Alberta, \$1,022; British Columbia, \$705; Manitoba, \$1,959; New Brunswick, \$680; Nova Scotia, \$401; Ontario, \$3,803; P.E.I., \$80; Quebec, \$378; Saskatchewan, \$744; Anonymous, \$8.00 — Total: \$9 780.

Have you made your donation yet?

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Outpost Nursing — A Challenge to Canadian Nurses

MURIEL I. SCHONBERG

AUTPOST nursing of the future will be a far cry from the grim epic of little log shacks and heroic nurses confronted with desperate emergencies and overwhelming situations. word "outposts" is a misnomer, leading one to visualize endless snow and long hard trips by dog-team while, in reality, any community twentyfive miles from a medical centre, hospital, or doctor is a medically unsupervised area. Babies are brought up by rule-of-thumb and mothers neglect prenatal visits because of rough roads and time-consuming trips. Minor defects, unless discovered during a chance visit to the doctor on some emergency mission, are ignored; babies come into the world without benefit of medical help and mothers drag around with neglected gynecological aftermaths in consequence. Malnutrition, rickets, and appalling dental conditions thrive in conjunction with shelf upon shelf of patent medicines at the general store, while one day's perusal of back files on health queries in the farm papers should make all connected with the medical profession writhe with shame at the discovery that it is necessary in this enlightened day and age, for any person to have to resort to such a source of information.

Since it is admittedly impossible for an impoverished small community to support a doctor, it follows that the nursing profession can contribute by sending specially qualified nurses to such isolated communities, thus bridging the gap. The outpost nurse is called upon to fulfil many functions, beginning with prenatal care, occasionally baptizing the asphyxiated infant, not infrequently playing hymns for a funeral or reading aloud prayers for the dving in half a dozen different faiths. These are unexpected qualifications, but the nurse is often the only educated individual in the community and, however little she knows about a subject, she can usually contribute a little more than anybody else. This is very well illustrated by a note handed in to me as I write:

Nurse — Our cow doesn't seem to make her water very good. What can we give her, and is the milk fit to use?

Veterinary knowledge comes with the years and home visits to well-run farms contribute greatly to a store of information which can, of course,



Ready for work

AUGUST, 1947

be casually passed on at the right moment to less enterprising home-The free booklets on cattle; steads. swine, and poultry, from the provincial department of agriculture, will usually clear up a mysterious complaint as together the farmer and the nurse study the index. Here, a knowledge of medical terminology will help. The farmer will in future know where to look for information and the nurse is left to reflect that the ailments peculiar to pigs and cows are not vastly different from human ailments and appear to stem from the same sources — malnutrition, lack of sanitation, and lack of cleanliness.

The first home visits in a new district are shattering in their revelation of ignorance and apathy in matters pertaining to health. Nor does the pattern vary to the slightest degree in any province of the Domin-Such visits require sympathy and diplomacy and they are never hurried. You may shudder to see the nine-months-old baby chewing a piece of rancid-looking salt pork, liberally smeared with dirt from the board floor or, in Indian settlements, a muskrat tail. You listen, outwardly calm, to tales of croup and convulsions and encourage the mother to talk of the remedies used; cow-dung, urine, and spittle play a large part in the remedies of the more primitive outposts - by no means confined to Indians. Anything so simple as a compress, after the time-honored remedy of a cow-dung poultice, lacks dramatic force, so it is never advisable to suggest it as an alternative. in conversation at least. An opportunity will arise before too long to give a practical demonstration of its simplicity and effectiveness. After all, Antiphlogistine can be substituted without too much loss of prestige. But, even while outwardly acquiescent, she is imagining in place of a pallid, rickety baby lying behind the kitchen stove, sucking a bottle of cold formula of undetermined composition and origin, a rosy-cheeked supervised baby, lying in the garden and fed correctly at regular intervals. If you have won the mother's confidence she will tell you the story of the baby's birth and, more often than not. about her difficult pregnancy and labor. If there were time to recount the thousands of stories such women have told with the simplicity of truth. you, too, would spare no efforts to bring about prenatal care for each and everyone, and make possible safe childbirth for every mother in Canada. If no doctors are available, then the trained hands of a nurse-midwife should be. The reason for the home visit may well be the result of a school inspection, a grand piece of strategy for gaining an entrance to every home. Who can resist the interest shown in the children of the family? School visits are the vital part of a well-planned campaign to capture the interest of the school children in healthful living, by combined instruction of parent, teacher, and child.

Often the children are fed inadequately. There is no doubt that farm children suffer greatly in this respect. The children are allowed to live through their school days in a filthy, verminous condition, with scabies, impetigo, or neglected sores. They are allowed, in addition, to mingle freely with unchecked, undiscovered tuberculosis. Finally, when communicable disease hits the community, they drag themselves through a neglected illness and suffer all their lives the sad consequences of deafness, impaired vision or hearing,

and crippled limbs.

The boil and other indications of a lowered resistance, sore enough to drag a man to his nearest doctor, are but a part of the picture. There is no one to tell the doctor that the family have had no garden, that they share one can of Carnation milk a day, including the baby's share, that they prefer white bread, salt pork, and pastry to anything thought up by the Department of National Health. Only a public health nurse has the time and entrée to the patient's home to deal with such problems, and to differentiate between conditions requiring immediate medical care by a doctor, and simple situations requiring good teaching.

There is no set procedure for the duties of a public health nurse. Every situation demands its own treatment, thus creating as varied and free a life as can be found any-

where in our profession.

After thirty or forty follow-up school visits, a picture of the health habits of the community can usually be obtained and program mapped out to meet their needs. If maternal and infant mortality exceeds normal, this could be the first campaign. Tuberculosis is not usually an overwhelming problem in the western provinces, thanks to the active preventive measures taken by the departments of health, the accessibility of free xrays and mobile clinics, and their careful checking of all contacts. is, however, quite another story among the Indian population and the provinces of the east. The percentage of defects is usually high, both in school children and in adults, and this is a heavy burden in any new district. Children with diseased tonsils have low resistance to respiratory infections and provide a lively source of infection for the rest of the school. Children with eve defects are often maladjusted, while abscessed teeth and chronic, discharging ears are only too common. The children and their defects are not the only problem. Neglected hernias, chronic appendices, or enlarged prostates sap the energy of the bread-winner. The nagging, scolding wife all too often reveals a chronic backache "ever since my first baby was born," and confesses shamefacedly "something hangs down outside her" which, being interpreted, usually means prolapsed uterus and its accompanying cystocele and rectocele. All this remedial work is a prelude to the future of a healthy physically fit community. Nothing should be too trivial for the nurse, for if the people feel free to come to her for small things, she will certainly be able to influence them in matters directly pertaining to their health and welfare. This is, naturally enough, very time consuming and could not be attempted in an organization with set duties and a



Another mode of transportation

time limit. The outpost nurse has very little bedside nursing, since distances are far too great for daily nursing care. If she existed solely to nurse the sick, her more important function of teaching the community how to keep well would inevitably be relegated to a spare-time activity.

There are, roughly, two approaches to outpost or district nursing. old idea was to have a nurse available for emergencies and illness. In the new approach she is responsible for the health of the community. The very ill patient should be nursed in hospital, for he requires expert attention twenty-four hours a day. This would be an impossibility in an outpost where one nurse is occupied with several hundred families. She can, however, train women who are free to be called upon in times of illness and childbirth. Many hospitals will help in this task by supplementing the classes held at the nursing station by a few weeks practical work as nurse's aide. With two or three such women in the district, it is possible to feel secure in the knowledge that a newly-delivered woman living twenty miles from the nursing station will not be left to be tended by a hastily instructed Apart from childbirth. relative. and chronic illnesses of old age, a wellrun district should produce little more than surgical emergencies and accidents. But to bring about such a metamorphosis means at least two years of relentless effort and teaching by demonstration, precept, and example. Adult education classes, mothercraft and home nursing groups. films, filmstrips, posters, school lunch

programs, visiting experts in cookery and handicraft, and animal husbandry are only a few of the means employed.

The above program sounds formidable, but it must be remembered that little more than general knowledge and common sense is required, provided the nurse's preparation for outpost nursing has been adequate. It cannot be emphasized too strongly that teaching in the majority of outposts is of the most elementary nature. Generally speaking, the more backward and primitive the community, the more ingenuity will have to be used to convince the people. For instance, in a halfbreed settlement, an experiment using four white rats produced a change of attitude, which two years of constant teaching had failed to provoke. The first pair were fed the children's own diet of bannock, lard, and boiled black tea without milk. The second pair received a more balanced diet which could easily be obtained locally, plus cod liver oil. The experiment had been planned for the children, but there were so many adult visitors that it was necessary to put the rats in the waiting-room of the office, where they caused a sensation, to say the least! That gruesome film, "The Housefly," and a gallon of DDT donated by the Red Cross and distributed free to the most fly-ridden houses, did more in a few days to convince the unbelievers in another community than years of weary reiteration could possibly have accomplished.

This is but a glimpse of the service that an outpost nurse can render to Canada. Every thinking man or woman must realize that if we are not to be crippled in the future by the general physical unfitness of thousands of men and women whom we have made little or no attempt to serve in the past, we must without

delay meet this challenge. There is abundant evidence that the lone trail of the outpost nurse is about to end.

The new and vital interest in Canada's lonely places shown by the Federal Department for Indian Affairs and the Canadian Red Cross has already demonstrated that this stepchild of the nursing profession, abandoned, neglected, and deserted, but for the missionary efforts of the few, is in fact about to blossom into a veritable "Cinderella," with electrically lighted homes and modern bathrooms to replace the haphazard living accommodation of the past. Radio communication and flying ambulances will space the terrifying gap between hospital and patient. The Northwest Territories are already mapped for strategically placed hospitals, equipped with a medical flying unit capable of moving patients to hospital at the radio request of the outpost nurse. The Red Cross, in several provinces, has built attractive homes, specially planned and equipped for outpost nurses, and, in addition, provides generous salaries, living expenses, and holidays with travelling expenses to headquarters.

It is not the purpose of this article to serve as a glamorous piece of recruitment propaganda, but rather to draw the attention of Canadian nurses to the new phase of Canadian nursing history which is about to commence. Before long, provided that the attention of the profession is aroused, steps will be taken to ensure the adequate preparation of would-be outpost nurses. In addition, conditions under which such nurses serve will be so attractive that, in return, we may expect an extraordinarily high standard of women capable of assisting in the building of a sturdy nation.

Heartburn

The most effective treatment of heartburn in pregnancy is the administration of cholinerges, of thiamine chloride and nicotinic acid, and dietary management. Reduction of the fat in the diet eliminating fried foods is frequently beneficial.

Anatomical Charts

The Anatomical Charts, prepared by Rudolf Schick Publishing Co., New York City, referred to in the review in the May, 1947, issue, are mounted on linen, with spring rollers, to give the charts a long life when much handled in schools of nursing.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Etude sur une Affiliation dans Sanatorium de Tuberculeux

Les infirmières ont encore à l'esprit les paroles du Dr. Vidal, président de la Commission de la lutte anti-tuberculeuse dans la province de Québec, paroles qu'il nous adressait lors de notre dernière assemblée annuelle. "Sans le concours des infirmières, la lutte contre la tuberculose est impossible," nous disait-il. Nous sommes donc en quelque sorte le gage du succès, en partie du moins, de cette lutte.

Ayant échangé à ce sujet des lettres avec Mlle Jeannette Loranger, infirmière du service de la Commission de la lutte anti-tuberculeuse, je me permets de publier quelques extraits de ces lettres et de soumettre à l'étude un plan pour une affiliation de deux mois dans un sanatorium de tuberculeux:

Si, comme vous le dites, le but proposé aux écoles d'infirmières par l'association est de permettre à l'infirmière, lorsqu'elle a terminé son cours, de donner des soins experts dans toutes les maladies, nous sommes loin, ie crois, d'avoir atteint l'idéal pour ce qui concerne la tuberculose. Toutesois, nous avons fait du progrès, mais si notre taux de mortalité reste si élevé comparativement aux autres provinces, c'est que nous n'avons pas fait ici tout ce qui était humainement possible de faire. La preuve, voyez Ontario, qui en 1945 avait 25.8 décès par tuberculose par 100,000 de population, Saskatchewan 26.9, alors que Québec se permet de s'afficher avec 71.8 (2,557 décès). Ces chiffres sont éloquents et nous disent n'est-ce pas que nous avons encore quelque chose à faire?

Aussi, j'aimerais à enrôler le plus grand

nombre d'infirmières possible dans la lutte que nous avons engagée contre cette maladie. A mon humble avis, il faudrait à tout prix que durant leur cours, les gardes-malades bénéficient d'un stage de deux à trois mois dans un hôpital spécialisé, comme celà se pratique en Ontario, en Saskatchewan, pour ne parler que de ces deux centres là. Ce qui s'est fait ailleurs peut se faire ici. Voici ce que pense l'Association des Infirmières de la Colombie-Britannique où le stage en T.B. est obligatoire pour toutes ses élèves infirmières.

Plusieurs sanatoria se plaignent de ne pouvoir avoir un personnel suffisant; les raisons données sont que l'on a peur de contracter la maladie ou que l'on n'a pas de connaissances spécifiques en tuberculose. L'Association des Infirmières de la Colombie-Britannique est d'avis que ces problèmes devraient être résolus durant le cours de l'élève infirmière, qu'un stage en tuberculose soit une partie de l'expérience que l'élève doit acquérir. Les problèmes précités seront résolus du fait même.

Comment veut-on que des infirmières diplòmées, qui ne se sentent pas préparées et qui n'ont aucun encouragement à le faire, choisissent comme champ d'action le soin des tuberculeux.

Néanmoins, ce champ d'action, s'il est bien mis en valeur, stimule l'intérêt de l'infrmière, son habileté aux soins des malades et augmente ses connaissances. Par conséquent, nous croyons que le stage dans un sanatorium donnera des résultats et qu'il est aussi important que toutes les autres expériences au programme.

Il est aussi reconnu que chaque membre de la société a son rôle à jouer dans la lutte anti-

AUGUST, 1947

TABLEAU DES COURS ET DES ACTIVITES SCOLAIRES POUR UNE AFFILIATION DE HUIT SEMAINES DANS UN SANATORIUM DE TUBERCULEUX

oirs	Dessins et explications de l'appareil à pneumothorax	Etude sur un sujet particulier		Rapport écrit des observations faites en laboratoire		. Oral	1	
Devoirs	Dessins et explications of pareil à pneumothorax	Etude sur un s		Rapport écrit des ob faites en laboratoire		Etude d'un cas.		
Activités scolaires	Visite de l'Institution				Discussion en groupe sur la T.B. pulmonaire etc.	Discussion en groupe sur la T.B. des os et des articulations	Discussion en groupe sur la T.B. de l'enfance	
Conférences	Conférence	Conférence médicale		Conférence médicale		Conférence médicale		
Démonstrations	Technique aseptique, etc. Pneumothorax et thoracen- thèse, (technique)	Observation d'une opération écrasement du nerf phrénique	Observation, inoculation, et post-mortem d'un cobaye			Epreuves à la tuberculine		
Cours	1. Présentation et renseignements 2. Histoire de la tuberculose 3. Tuberculose pulmonaire A 4. Tuberculose pulmonaire B 5. Pathologie, anatomie et physiologie 6. Prélèvements (comment recueillir les) et technique de laboratoire 7. Service des repas	1. Traitement général de la tuber- culose pulmonaire	Prévention et contrôle de la tuberculose dans la Saskatchewan Tuberculose osseuse et articulaire	1. Traitement de la T.B. pulmo- naire en chirurgie 2. Mfection non pulmonaire état tuberculeux	 Observation des suites de la maladie (follow-up) Récapitulation 	1. Epidémiologie et la vaccination par le B.C.G.	Orientation professionnelle et	Revue des questions de l'examen fin il
Semaine de				N1	>	I.V	VII	VIII

Examens: 1ère semaine — Examen d'appréciation. 8e semaine — I

8e semaine - Examen final.

tuberculeuse. Un programme éducatif est nécessaire afin que chaque individu connaisse ses responsabilités envers la société.

Le succès d'un programme d'éducation dépend de l'activité, de l'intérêt et des qualifications d'un personnel bien entraîné. Les infirmières quelque soit leur champ d'action sont toutes indiquées pour enseigner les points importants de la prévention et du contrôle en T.B.

Mais ce n'est que par une affiliation que l'on peut faire réaliser aux infirmières l'étendu du problème tuberculeux et du fait stimuler leur intérêt et leur donner les connaissances nécessaires et les moyens d'y remédier. C'est la contribution qu'elles doivent apporter comme citovenne de leur société et comme membre de leur profession.

Un programme très intéressant, venant de l'Association des Infirmières de la Saskatchewan, où ce projet a été mis à exécution avec beaucoup de succès, au Sanatorium de Fort Qu'Appelle, est publié ici.

Ces quelques feuilles doivent accompagner le tableau des diverses activités durant les huit semaines d'affiliation:

- 1. Buts du cours: De familiariser l'infirmière avec la tuberculose. La prédominance de la maladie. Les symptômes (et l'absence fréquents de symptômes). Le traitement subjectif. L'expérience pratique du traitement au sanatorium.
- 2. D'enseigner à l'étudiante infirmière que la tuberculose est contagieuse et faire ressortir la valeur de la prévention et du contrôle. Mesures protectives pour l'infirmière et pour les autres membres du personnel. Education du patient afin qu'il retire le maximum de bénétice de son traitement et qu'il restreigne le danger d'être une occasion de péril pour la société. Occasions se présentant en hygiène publique. Adaptation psychologique nécessaire pour venir en contact avec les patients tuberculeux.

3. Ann d'enseigner à l'elève la nécessité de la réhabilitation et les moyens pour y parvenir.

Etat de santé et examen médical: Les étudiantes sont supposées venir au sanatorium en bonne santé. Toutes les étudiantes doivent avoir eu une réaction positive à la tuberculine ou avoir reçu du B.C.G. La vaccination doit avoir lieu lors de l'entrée de l'élève à sa propre école.

Au début du cours d'affiliation, chaque élève a une radiographie pulmonaire et un examen médical comprenant, analyse d'urine, et analyse du sang. En cas de maladie, l'élève est vue immédiatement par un médecin et l'école est avertie. Avant de quitter le sanatorium, chaque affiliée a une autre radiographie pulmonaire et un examen médical si on le juge à propos.

de l'Institution: Par La visite groupes, l'on conduit les affiliées dans les départements les plus importants, là où elles auront à aller durant les premiers jours. Après cette visite, chaque étudiante est conduite dans la salle où elle doit travailler et présenter à l'hospitalière. L'hospitalière aide à orienter la nouvelle venue en lui donnant des détails sur la salle. en lui présentant les autres membres du personnel et les patients dont elle

prendra soin.

Les cours théoriques: Ils sont donnés durant la première semaine du stage hospitalier à raison de deux par jour, afin de donner aussitôt que possible une base au travail pratique. De cette façon, l'adaptation au milieu est beaucoup plus facile pour l'étudiante et celà lui permet dès le début de se protéger et de protéger les autres des dangers de l'infection et en plus celà lui permet de donner des meilleurs soins aux patients.

Les conférences médicales sont consacrées à la tuberculose pulmonaire parce que c'est la forme qui prédomine. En autant que la chose est possible, des cas illustrant le sujet discuté sont choisis parmi les patients du sanatorium et présentés lors de ces conférences.

L'un des cours est donné en partie sur la vaccination par le B.C.G., sa valeur, et son emploi chez l'infirmière étudiante sont soulignés. La diététicienne discute de la nutrition en tuberculose et décrit le service alimentaire de l'institution.

Les cours sur la prévention, la surveillance des malades sortis du sanatorium (follow-up) sont donnés par les personnes en charge des départements intéressés. La directrice des infirmières parle aux étudiantes de l'attitude professionnelle et de l'orientation pour la future infirmière

diplômée.

Démonstrations: L'on fait un pneumothorax et une thoracentèse devant un groupe. Chaque étudiante a l'occasion d'assister pour ces mêmes opérations durant la semaine qu'elle passe à la salle d'opération. L'on permet à l'étudiante d'observer toute, opération chirurgicale importante. Au laboratoire l'étudiante observe les inoculations aux cobayes et est présente lors du post-mortem.

Devoirs: Une histoire de cas est préparée par chaque étudiante et présentée oralement à l'institutrice. L'importance de l'éducation du pa-

tient est souligné.

Conférences médicales: Les étudiantes ont la permission d'assister chaque semaine à la conférence du personnel médical. Les médecins présentent des cas nouveaux pour diagnostiser et discutent le cas de patients du sanatorium, de leurs progrès, de traitements nouveaux, ou de leur congé. Les élèves voient la valeur de ces conférences, elles écoutent les opinions de tous et la décision prise.

Occasion spéciale d'éducation: Lors-

que quelque chose de spécial se présente, l'on en fait bénéficier les élèves.

Examens: L'examen d'appréciation au début du cours a pour but de se rendre compte des connaissances de l'élève en anatomie, physiologie, bactériologie, etc., se rapportant à l'étude de la tuberculose. Celà permet à l'élève de revoir une partie de ces matières qu'elle a pu oublier.

L'examen final est du type objectif. Les questions sont revues le lendemain de l'examen, les corrections sont faites, et tout ce qui n'est pas clair est

expliqué de nouveau.

Rapport à l'école: Un rapport complet sur la théorie et la compétence qu'a l'élève est préparé par l'hospitalière de la salle où l'infirmière a travaillé. A la fin de son stage dans la salle, l'hospitalière a un dernier entretien avec l'élève, elle lui remet son rapport, l'élève le lit et le signe.

Cette évaluation est faite selon "Study Guide on Evaluation" de R. Louise McManus, National League of Nursing Education. Nombre total de points, 200; étude sur un sujet particulier, 15 à 30 points; histoire de cas, 10 à 20 points; examen final, 75 à 150 points. Le pourcentage est calculé en divisant le total par deux.

Nurse Instructors Hold Institute

Following the annual meeting of the Saskatchewan Registered Nurses' Association, for the third time a one-day institute for instructors in schools of nursing was held at the Hotel Saskatchewan, Regina. Noreen Lambert, instructor at the Holy Family Hospital, Prince Albert, and the retiring chairman of the Hospital and School of Nursing Section, presided, and K. Probert, instructor, Regina Grey Nuns' Hospital, acted as secretary.

Those attending were: Rev. Sr. Loretta, St. Elizabeth's Hospital, Humboldt; L. Garland, A. Aldridge, M. Palmer, and E. Hennigar, Regina General Hospital; C. Crowe, Fort San; M. Richardson, Saskatchewan Hospital, North Battleford; V. Parker, Victoria Hospital, Prince Albert; C. Lennie, J. Salte, and B. Fisher, Moose Jaw General Hospital; J. Hodsdon, P. Graham, E. Jefferson, and Y. Nishamura, Regina Grey Nuns' Hospital; Rev. Sr. Mandin, F. McDonald, E. Worobetz,

M. Robinson, and S. Leeper, St. Paul's Hospital, Saskatoon; L. Willis, Saskatoon City Hospital; E. James, Yorkton General Hospital; Rev. Sr. Loretto, Holy Family Hospital, Prince Albert; Mrs. Naomi Koshnysh and H. Rutherford, Providence Hospital, Moose Jaw; K. W. Ellis, University of Saskatchewan School of Nursing; C. E. Jackson, travelling instructor, S.R.N.A.

Discussion centred around the teaching programs in schools of nursing; preparation for the First-Year Qualifying Examinations, which are to be held in Saskatchewan for the first time this year; the importance of clinical teaching and the special functions of clinical instructors. Course outlines for guidance in schools of nursing in Saskatchewan were also reviewed, and rating scales. A number of recommendations were prepared for the consideration of those responsible for the administration of schools and the S.R.N.A.

Notes from National Office

Exchange of Nurses Committee

A CTION was authorized by the above committee along the following lines: (1) approach to the appropriate governmental authorities; (2) obtaining legal counsel; (3) limitation of exchange privileges; (4) selection of candidates; (5) selection of initial practice fields and the appointment of a sub-committee to explore them; (6) extension of exchange privileges to Canadian nurses

who wish to go abroad.

The general secretary visited Ottawa and was accorded a sympathetic hearing by officials of the Department of External Affairs and the Department of Immigration. officials seemed interested in the project and saw no reason why it should not succeed, provided due care is taken to make certain that all regulations are scrupulously observed. Legal counsel was sought and steps are now being taken to draw up a suitable contract which will protect the interests of all concerned. It was agreed that exchange privileges would be granted to such persons as are able and willing to fulfil the conditions outlined by the Exchange of Nurses Committee and endorsed by the Canadian Nurses' Association. Tentative general principles, which should govern the selection of candidates, have been outlined and will be modified and expanded in the light of future experience. It was agreed that, at the outset, it would be wise to assign candidates to the Montreal area in order that they might be closely in touch with the National Office of the C.N.A., through which arrangements for their entry to Canada will officially be made. It is understood that practice areas in other parts of the country will be developed rapidly in

the light of the initial experience thus obtained.

A sub-committee of Montreal members was appointed to explore the area in question. Considerable spadework has already been accomplished by this sub-committee and the response of both the English and French hospitals has been quite encouraging. The sub-committee is now engaged in formulating tentative programs of experience and in drawing up schedules for salary and maintenance which will be acceptable to all concerned. It was agreed that the primary aim of the Exchange of Nurses Committee is to provide exchange privileges for Canadian nurses in as full a measure as for nurses abroad. It was admitted, however, that this aim is greatly complicated by the severe conditions prevailing in Great Britain and on the continent. It was decided that the chairman and the secretary of the Exchange of Nurses Committee should jointly seek advice from various official agencies such as the Royal College of Nursing and the British National Nursing Council concerning the admission of a few carefully selected Canadian nurses who would adjust satisfactorily without adding to the burden of the directors of the institution in which they are received.

Joint Committee Canadian Hospital Council and C.N.A.

At a meeting of the above committee, discussion centred around the following topics: (1) nursing service in hospitals and the reasons for shortage of staff; (2) nursing education and the need of a time-study and cost analysis; (3) personnel policies; (4) the need for informing the public and the medical profession in regard to the above points; (5) the control of

AUGUST, 1947

admissions in hospitals. The following recommendations were approved:

That the offer of the Canadian Medical Association to undertake a campaign of education of their members be heartily endorsed and accepted.

That hospital salaries be brought into line with the standard practice for comparable work and preparation in the centres concerned.

That hours of duty and pensions should conform to a similar standard practice.

That the principle of the 48-hour week be supported with preferably a 44-hour week when personnel permits.

That all groups of persons providing nursing care for gain should be placed under licensure in every province.

That the Joint Committee, through the Canadian Hospital Council, recommend to the provincial hospital associations that they ask their member hospitals to set up records and bookkeeping entries in accord with some accepted uniform pattern in order to make it possible to obtain data which will be of use in ascertaining the real cost of nursing education and of nursing care and service.

That the Joint Committee endeavor to obtain the funds necessary for a proper investigation of the serious situation existing in regard to nursing and that, as the problem is a national one, the first approach be made to the Department of National Health and Welfare.

That the question of admission to hospitals be left to a sub-committee of the Canadian Medical Association and the Canadian Hospital Council and the following suggestions passed on to the sub-committee: The need for more convalescent homes to be stressed, a greater use of clinics for treatment and diagnosis, and that internes should be taught not to order unnecessary treatments.

Following this meeting a brief, asking for a grant of money to enable us to conduct a scientific job analysis and cost study of nursing and nursing education, was prepared and presented to the Minister of Health and Welfare. The Minister received the delegation and gave generously of his time and attention and offered to make any suitable personnel from his department available for the study. No promise of financial help was received and we were advised to seek

such help from the provincial departments of health as both education and public health come under the jurisdiction of the provinces.

When the committee again met it was decided to (a) ascertain the possibilities of receiving financial assistance to carry out the proposed study and (b) arrange for an interview with an expert from the International Health Division of the Rockefeller Foundation who could give advice as to the best method of conducting such a survey.

The question of hospitals throughout the country undertaking to train nurses' aides, as urged in a letter from the American College of Surgeons, was brought up and it was recommended that an article opposing such a wide-open policy should be published in *The Canadian Hospital* for the information of all hospitals.

British Nurses Relief Fund

The following contributions have been received from:

Children's Memorial Hospital, Montreal \$15.00.

Alumnae Association, Homoeopathic Hospital, Montreal \$15.00.

Manitoba Association of Registered Nurses \$5.00.

Alberta Association of Registered Nurses \$141.00.

Visits

The general secretary gave an address and took part in discussions at the meeting of the Maritime Hospital Association at St. Andrews, N.B., June 4-6, choosing as her topic "The Present Situation in Nursing." General emphasis was, however, placed on the importance of sound personnel policies and practices by employers of nurses.

The general secretary attended and took an active part in the Institute for Registry Personnel, held at the Royal Connaught Hotel, Hamilton, Ont., June 9-11. This institute was organized and convened by Miss M. Baker, registry adviser, Registered Nurses Association of Ontario. Two sessions, directed by the general secretary, were devoted to the discussion

of the all-important and timely subject of Public Relations.

Letter of Appreciation

Amsterdam, June 10, 1947.

To the Canadian Nurses' Association:

Now that we are again in Holland, all comes back to us quite vividly. How very much we enjoyed our most interesting trip to the U.S.! You can't half know how many fine impressions we have carried home with us. The financial help given to us makes us very grateful to you, for we could not otherwise have managed to come. Things are still so hopelessly involved that, but for your generosity, we should never have left Europe.

Our stay in the U.S. has meant very much to us, not only because of what we saw and what we got, but also of the personal contacts we had, and which we thoroughly enjoyed. It stimulates us to take up our tasks again in Europe, where everything is so quite different and circumstances are so hard to tackle. So, also on behalf of our delegates, I thank you most heartily for all you did for us.

We all hope that the future may bring us together again. Whenever one of you should come to Holland, please let us know. We should be so happy to have you here.

With kindest regards,

Yours sincerely,

C. H. Menalda, President.

Notes du Secrétariat de l'A.I.C.

LE COMITE d'ECHANGE d'INFIRMIERES

Le comité prit les décisions suivantes concernant les possibilités d'échanger des infirmières des pays d'Europe contre des infirmières canadiennes: (1) avoir une entrevue avec le gouvernement; (2) obtenir l'opinion de notre aviseur légal; (3) restrictions apportées aux échanges; (4) choix des candidates; (5) choix des lieux de l'expérience et la nomination d'un souscomité pour étudier cette question; (6) que le même privilège soit offert aux infirmières désireuses d'aller outremer.

La secrétaire général alla à Ottawa et eut une entrevue avec les autorités du Département des Affaires Extérieures et du Ministère de l'Immigration. Les autorités virent ce projet d'un oeil favorable et ne voient aucun obstacle à son succès pourvu que l'on observe avec soins scrupuleux tous les règlements.

L'aviseur légal est à préparer un contrat pour protéger les intérêts de tous.

Il fut décidé que seules les infirmières pouvant remplir les conditions émises par le comité d'échange d'infirmières pourront bénéficier de l'échange. Quelques principes généraux, qui seront modifiés à la suite des premières expériences, ont été tracés.

Il a été décidé, qu'il serait sage, du moins au début, que les candidates soient placées à Montréal, afin qu'elles soient près du secrétariat national, lequel fera les démarches officielles pour l'obtention de leur entrée au Canada. Il est bien entendu que plus tard d'autres centres seront ouverts. Les hôpitaux de langue française et de langue anglaise ont accueilli ce projet très favorablement. Actuellement le sous-comité prépare un programme, une échelle de salaires, et détermine les conditions de travail qui seront convenables pour tous.

A cause des conditions actuelles difficiles en Europe, l'envoie d'infirmières canadiennes est très compliqué et il a été décidé, qu'avant d'envoyer une infirmière canadienne, qu'une sérieuse étude sera faite, afin de se rendre compte qu'elle ne sera pas à charge.

LE COMITE CONJOINT

Les questions suivantes furent discutées lors de l'assemblée du comité du conseil des hôpitaux et de l'Association des Infirmières du Canada: (1) le service des infirmières et les causes de la pénurie d'infirmières; (2) la formation de l'infirmière, la nécessité d'étudier le temps nécessaire à cette formation et d'en analyser le coût; (3) politique à l'égard du personnel; (4) la nécessité de renseigner le public et les médecins sur les questions déjà mentionnées; (5) contrôle des admissions à l'hôpital.

Les recommandations suivantes furent faites; Que l'offre de la "Canadian Medical Association" soit acceptée, à savoir: Que l'association entreprenne une campagne éducative parmi ses membres concernant les problèmes hospitaliers. Que les salaires dans les hôpitaux soient l'égal de ceux généralement payés en comparaison du travail et de la préparation des membres. Qu'il en soit de même pour les heures et les conditions de travail. Que l'on accepte le principe de la semaine de 48 heures mais de préférence de 44 heures lorsque le personnel est suffisant. Que toutes les personnes donnant des soins aux malades moyennant rémunérations aient une licence provinciale.

Le comité conjoint recommande, par l'entremise du Conseil des Hôpitaux, à toutes les associations provinciales d'hôpitaux d'adopter le même système de comptabilité et les mêmes formules, afin qu'il soit possible d'établir le coût réel de la formation de l'infirmière et le coût du soin aux malades. Et le comité demande l'aide du gouvernement fédéral pour faire ces analyses.

Que la question de l'admission des patients soit laissé aux soins du Conseil des Hôpitaux du Canada et au "Canadian Medical Association" et que les points suivants soient étudiés par un sous-comité: Le besoin d'un plus grand nombre d'hôpitaux de convalescents; que l'on se serve d'avantage des hôpitaux pour les besoins de diagnostic et de traitements; et que l'on enseigne aux internes de ne pas prescrire de traitements qui ne sont pas nécessaires.

Après l'assemblée, un résumé fut préparé et présenté au Ministre de la Santé et du Bien-Etre concernant l'obtention d'un octroi pour l'étude de la formation de l'infirmière et le coût de cette formation. Le ministre suggéra que cette requête soit présentée aux ministères provinciaux puisque la santé et l'éducation relèvent des provinces.

A la réunion suivante du comité, il fut décidé: (a) de s'assurer d'une aide financière pour conduire l'étude préposée; (b) qu'une entrevue soit demandée avec un expert de "International Health Division of the Rockefeller Foundation" afin d'avoir son avis sur la meilleure manière de conduire cette étude.

La question de former des aides dans les hôpitaux tel que demandé par "American College of Surgeons" a été présentée et il fut décidé qu'un article s'opposant à un plan aussi général soit publié dans *The Canadian Hospital*.

VISITES

La secrétaire générale de l'A.I.C. adressa la parole lors de l'assemblée de l'Association des Hôpitaux des Provinces Maritimes à St-Andrews, N.B., le 4-6 juin. Elle parla de la situation actuelle du nursing.

REMERCIEMENTS

Les infirmières de Hollande, de retour dans leur pays, remercient l'A.I.C. dont la générosité leur a permi d'assister au congrès international. Ce bref séjour en terre d'Amérique a été une inspiration, un stimulant, et un réconfort qui leur permettront de continuer leur travail même dans les conditions difficiles actuelles.

Annual Meeting in Alberta

The twenty-ninth annual meeting of the Alberta Association of Registered Nurses was held April 18-19, 1947, at the Palliser Hotel, Calgary, with the president, Miss Barbara A. Beattie, in the chair. One hundred and thirty-seven members, representing fifteen centres, registered. An address of welcome on behalf of the city of Calgary was given by the deputy mayor, Mr. F. R. Freeze. A telegram of good wishes and greetings from Miss Evelyn Mallory, president, R.N.A.B.C., was read

In her presidential address, Miss Beattie mentioned the positions of significance that had been filled during the past year by Albertans and paid special tribute to Miss Rae Chittick, of Calgary, president of the Canadian Nurses' Association.

EDUCATIONAL POLICY: Miss Helen E. Penhale reported the progress being made.

1. Expansion of clinical facilities: Subcommittees have drafted basic forms for use if and when tuberculosis sanatoria, mental hospitals, and selected rural hospitals are used as affiliation institutions for student nurses. Progress is being greatly delayed in starting these affiliations due to not having an adviser for schools of nursing in Alberta. Greatest advance is being made in connection with the tuberculosis sanatorium at Calgary.

- 2. "Regulations Governing Schools of Nursing in Alberta," as issued by the University of Alberta. This pamphlet is being revised and will be available in the autumn of 1947.
- 3. Central school of nursing: This idea grew out of the resolutions sent by the C.N.A. following the biennial meeting in Toronto, July, 1946. The provincial committee, formed to deal with the resolutions, delegated the work of drafting material regarding a central school plan to the nurse representatives.
- 4. Institute on tests and measurements: In response to requests that assistance be given to instructors, supervisors, and head nurses in schools of nursing in connection with examination papers modern trends, setting, evaluating, etc.—an institute was arranged to be held at the University of Alberta in June. Miss Helen E. Penhale, M.A., director of the School of Nursing, University of Alberta, and Rev. Sister Jeanne Forest, M.A., educational director, Holy Cross Hospital, Calgary, conducted the course which was sponsored by the A.A.R.N.

5. A.A.R.N. Library: The A.A.R.N. Library is housed with that of the School of Nursing, University of Alberta. During the year the books were catalogued and policies formulated. Publicity is planned by having information concerning the library on the revised annual membership cards.

HEALTH INSURANCE: Miss F. E. C. Reid reported that a brief had been submitted to the Department of Public Health.

LEGISLATION: Miss Margaret S. Fraser reported that this committee had been very active during the year in connection with (1) the C.N.A. Constitution and By-Laws; (2) the new minimum education requirements for admission to schools of nursing; (3) preparation of a second Digest to help secure happier, more contented nurses, better nursing service, and more business-like personnel policies between nurses and employers of nurses; (4) necessary amendments to the present A.A.R.N. By-Laws.

The chief By-Law amendments, approved by the general meeting, related to: (1) The personnel of the Council; (2) standing committees; (3) district and chapter associations; (4) increase of registration fee for reciprocal registrants from \$7.00 to \$10.00.

Minimum education requirements for ad-

mission to schools of nursing: Section 4 of the Registered Nurses' Act, 1941, was amended by the Alberta Legislature and assented to March 21, 1947. The new regulations state the minimum is not fewer than sixty-seven high school credits which shall include "B" standing or higher in the following subjects, viz.: English 1 and 2, one foreign language 1 and 2, algebra 1, geometry 1, physics 1 or biology 1, chemistry 1, health 1 and physical education 1, or has obtained in Alberta or elsewhere an equivalent educational standing. Until June 30, 1949, applications will be considered of students who meet the requirements of either the 1947 Amendment or the 1941 Registered Nurses' Act.

LABOR RELATIONS: Miss Barbara A. Beattie made reference to the following: (1) that the "principle of superannuation" was generally accepted for Alberta hospitals at the convention of the Associated Hospitals of Alberta held in November, 1946; (2) that the salaries for graduate nurses are well above the minimum proposed by the A.A. R.N. in 1945; (3) that the staff situation in hospitals has improved, both from the standpoint of numbers and stability; (4) that more subsidiary workers are being employed in hospitals; (5) that more hospitals have adopted the 48-hour week.

Partly in response to a resolution passed at the general meeting, 1946, a Digest was prepared by the Labor Relations and Legislation Committees to help nurses and nurse employers. The Digest was discussed at the meeting and it was decided to request the advice and co-operation of the Associated Hospitals of Alberta. The Digest is not yet ready for general distribution.

NURSE PLACEMENT SERVICE: Miss Margaret Cogswell reported that since the Nurse Placement Service was instituted in September, 1945, she had visited 82 of Alberta's 104 hospitals. Since April, 1947, N.P.S. has been operated in conjunction with National Employment Service. Nurses' salaries, generally speaking, have been raised considerably during the year. A fairly average salary for general duty nurses in small hospitals is \$110 per month in addition to maintenance.

NURSES' ACT AND BY-LAWS: Miss Madeline McCulla spent considerable time in outlining the revisions that had been made. Discussion took place following which it was

decided that the Nurse Practice Act Committee should do further work and present a report at the general meeting, 1948.

Subsidiary Workers: Miss Margaret S. Fraser reported that the A.A.R.N. was active on a committee appointed by the Minister of Health in 1946 to prepare a "Licensing Act for Nursing Aides." The Act was assented to March 21, 1947. The Advisory Committee, A.A.R.N., at the request of the Department of Health, prepared the curriculum for use in the C.V.T. School in Calgary for nursing aides. Miss Frances Ferguson, director of the school and registrar-consultant for nursing aides, gave an interesting description and report of the school.

Funds for Nursing Projects: (1) War Memorial Trust Fund: Miss Margaret Thompson, chairman, explained the purpose and plan and urged that donations be made. (2) Toward expenses of Dutch nurse-delegates to I.C.N. Congress: \$148 was donated. The quota was over-subscribed by \$23. (3) Rest-Break Homes and British Nurses Relief Fund: The need was explained and the plan discussed; \$141 has been donated to date.

DISTRICT REPORTS were given by representatives. The nurses of Medicine Hat District (approximately 45 in number) re-

ceived special acclaim and tribute for the raising of \$1,032.57 during the past year.

Hospital and School of Nursing: Miss Anne Anderson reported on the assistance given with the revision of the A.A.R.N. By-Laws; formulating of requirements for rural hospital affiliations; arrangements for an article on personnel policies to be printed in *The Canadian Nurse*.

GENERAL NURSING: Mrs. Bertha Kipp gave an outline of the changes effected in fee schedules for private duty nurses in Lethbridge, Calgary, and Edmonton.

PUBLIC HEALTH: Miss E. Irene Stewart gave an account of the meetings of the year.

The above three sections in the A.A.R.N. were discontinued in accordance with the C.N.A. policy and replaced by: (1) the Committee on Institutional Nursing; (2) the Committee on Private Duty Nursing; (3) the Committee on Public Health Nursing.

The guest speakers were Dr. Charlotte Whitton, C.B.E., Ottawa, and Dr. E. P. Scarlett, Calgary. Miss Rae Chittick, president of the Canadian Nurses' Association, discussed various major activities of the C.N.A.

E. Bell Rogers
Registrar, A.A.R.N.

Annual Meeting in British Columbia

Two hundred and thirty-six nurses, representing thirty-six communities, registered for the day sessions at the annual meeting of the Registered Nurses' Association of British Columbia held at St. Paul's Hospital, Vancouver, on April 11-12, 1947. The attendance Friday evening at Shaughnessy Hospital was well over three hundred.

Miss Evelyn Mallory presided at all sessions. In her presidential address she

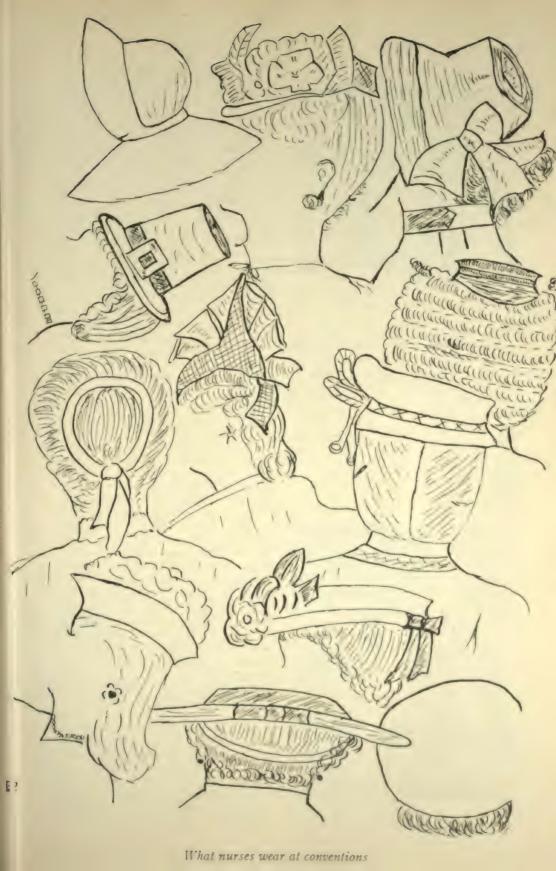


D'Arcy Studios, Vancouver Convention exhibit

reviewed the objectives and some of the changes accomplished in the revision of the C.N.A. Constitution and By-Laws; the plans for a demonstration of an independent school of nursing; and the organization and objectives of the Joint Planning Committee on Nursing. She also reviewed the functions of districts and chapters and urged delegates "to take back to their respective groups our plea for more active participation in professional affairs."

The reports from the seven districts showed that the chapters and districts are holding regular meetings with varied programs, are taking an active part in civic affairs, and are ably representing and interpreting nursing in their respective communities.

Miss Paulson's report on Health Insurance and Nursing Service emphasized that the solution of problems of nursing service





D'Arcy Studios, Vancouver

Canadian Nurse exhibit

shortage and the development of more comprehensive curricula in schools of nursing are fundamental in planning constructively for health insurance. The convener of the Publications Committee reported an active year. The exhibit prepared by the Vancouver Chapter's Canadian Nurse representatives drew attention to the many contributors from this province. The report from the Joint Planning Committee on Nursing covered the work done by this committee since its inception last summer, including the findings of an activity analysis carried out in hospitals, the preparation and distribu-



Don McLeod, Vancouver

Illustrating branches of nursing

tion of a guide for on-the-job training of hospital aides, and the major features of a plan for a central school of nursing in British Columbia.

The registrar reported that student enrolment in schools of nursing has been maintained at the high level reached in the latter years of the war and that the number of currently registered nurses and of new registered nurses increased over the previous year by approximately 9.5 and 28 per cent respectively. Her report included an estimate of present shortage of nursing personnel and of requirements in the next few years. It also included a summary of the brief submitted to Mr. Graham Davis, who was commissioned by the provincial government to make a survey of hospital needs, and outlined briefly British Columbia's policies connected with the registration of nurses who come to us from other provinces and countries.

The reports from the Placement Service Committee and from the director of Placement Service reviewed expansion of this service as indicated by an increased enrolment for placement and a startling increase in the number of private duty calls handled by the directories in Vancouver and Victoria. The committee's report contained the fee schedule for practical nurses working in homes which was drawn up by the committee and Miss Braund summarized the results of the experiment in placing practical nurses.

Miss Emily Nelson described the dinner meeting which was attended by student delegates from the seven schools of nursing at which the Student Nurses' Association of British Columbia was formally organized. Miss Nelson was elected honorary president and Miss Margaret Roddan, of the Royal Columbian Hospital School of Nursing, president. The purposes of this new association are to promote professional interest and to help students to prepare themselves for the added responsibilities they will face as graduate nurses.

The Friday evening session was devoted to various phases of the "economic security" program. Miss Ruth Morrison, of the U.B.C. Department of Nursing and Health, introduced the topic. Miss Copeland's report on the Labor Relations Committee reviewed the work of this committee since its inception in 1943 and explained the purpose for which the bulletins on employeremployee relationships were prepared and distributed to nurses at their place of em-

ployment. Reference was made to the C.N.A. memorandum on unemployment insurance and to the committee study of this subject. The registrar reported on the Select Committee on Labor Relations. The work of this committee is in its infancy but the fact that seven employee groups of nurses had elected members of this committee to act on their behalf as certified bargaining representatives indicates that nurses are turning to their professional association for assistance in solving their economic and other problems. The report on the 1947 R.N.A.B.C. personnel practices evoked much discussion.

Miss Creasor, convener of the Legislation Committee, presented the proposed amendments to the Constitution and By-Laws. They were voted on and approved with one additional amendment — the committees on Labor Relations and Health Insurance were made standing committees.

The attendance at the luncheon was 148 and Mrs. Rex Eaton, in her address on "Women in World Affairs," told of the International Assembly of Women which met in New York last fall. The St. Paul's Hospital Alumnae Association was hostess at a delightful tea which came at the end of two days of strenuous meetings.

ALICE L. WRIGHT

Executive Secretary, R.N.A.B.C.

Annual Meeting in Manitoba

The thirty-third annual meeting of the Manitoba Association of Registered Nurses was held April 21-22, 1947, at the Fort Garry Hotel, Winnipeg. The meeting opened with the Public Health luncheon at noon, April 21. The address of welcome was given by His Worship, Mayor Coulter, and the guest speaker was Dr. E. F. Willoughby, principal of Kelvin Technical High School. His address, "Ramparts of Peace," dealt with UNESCO and the meeting at Paris where he was delegate from Canada. At the afternoon session reports were heard from the president, executive secretary, president of the Manitoba Student Nurses' Association, and the graduate nurses' associations. In the evening the speaker was Mr. T. W. Laidlaw, K.C., who was introduced by the Hon. C. Rhodes Smith, Minister of Labor. Mr. Laidlaw's address was en-

titled "Collective Bargaining" and was most timely and informative. He answered many questions which arose during the discussion period.

Tuesday morning was given over to reports from the sections, standing and special committees, and representatives. The two speakers during the afternoon were Miss Alice Smith, Cancer Institute, and Dr. E. L. Ross, medical director, Manitoba Sanatorium Board, their respective topics being "Cancer" and "Tuberculosis." The climax to a successful annual meeting was the banquet held Tuesday night with a record attendance. Dr. Athol Gordon was the guest speaker, choosing as his topic "The Nurse in this Changing Age."

LAURA B. FAIR

Executive Secretary, M.A.R.N.

Annual Meeting in Ontario

The twenty-second annual meeting of the Registered Nurses Association of Ontario was held at the Royal Connaught Hotel, Hamilton, on April 23-25, 1947. Following the opening of the meeting by the president, Miss N. D. Fidler, a welcome from the City of Hamilton was extended by Mayor Lawrence, and from the district by the chairman, Miss Anna M. Oram. We were pleased to have with us Miss Margaret E. Kerr, editor and business manager of The Canadian Nurse, who brought greetings from the National Office and also expressed her appreciation of the opportunity to attend the annual meeting and meet with members from all parts of Ontario. A message from

Miss Rae Chittick, president, Canadian Nurses' Association, was read by the chairman.

The president, Miss N. D. Fidler, presided at all business sessions. A folio of the reports was prepared in the provincial office and distributed to all who registered. This plan made it possible for the delegates to follow the reports as presented for discussion and the folio will be of assistance to them when writing up their report of the meeting. The registration for the full meeting was 415 with an additional number of 394 who attended one or more sessions.

One of the important questions for discussion on the first day was the presentation of the proposed draft of a Nurse Practice Bill by the convener of the Legislation Committee, Miss Mary B. Millman. The proposed draft was in two parts to include both the professional nurses and the nursing assistants. The proposed draft was fully discussed, point by point, on the first day and, for the benefit of those who were unable to attend, a summary was presented by the convener on the second day, when an opportunity for further discussion was provided. The decision as to whether a bill embodying the principles outlined in the proposed draft should be prepared was made in a ballot vote. The result of the voting indicated that a large majority were in favor of a bill and, following the presentation of this report, authority to proceed with the preparation of a bill was granted.

The Hospital and School of Nursing and the Public Health sections held their business meetings concurrently on the morning of April 24. The arrangement made in 1946, that the General Nursing section hold their business meeting at 5 p.m., was again followed this year, as it was the opinion that many more private duty nurses were able to attend at the later hour.

A panel discussion on "Nursing as a Community Service" was conducted under the able chairmanship of Miss Edna L. Moore. Those who assisted with the panel were keenly interested in the topic and discussed the following points: "The Community"-Prof. C. W. M. Hart, M.A., associate professor and supervisor of studies in Sociology, University of Toronto; "Community Needs" - Mr. James Dutton; "The Legislator and Nursing"- Dr. R. Hobbs-Taylor, M.D., M.L.A., provincial member for Huron constituency; "Problems in Meeting Community Needs"- Miss Helen M. Carpenter, M.P.H., director of nursing service, East York-Leaside Health Unit, and Miss Lucy M. Ashton, health supervisor. Hospital for Sick Children. The interest of the delegates in this session was demonstrated by an attendance of approximately six hundred.

On Thursday evening, April 24, 460 attended the annual dinner when Miss Nora Frances Henderson, controller for the City of Hamilton, spoke on "The Place of Women in Democracy." In her address Miss Henderson pointed out the authority which women could exert, both as individuals and as groups, encouraging them to take a constant and practical interest in the affairs of their communities and their country.

The association appreciated the support and co-operation of the twelve commercial firms whose exhibits were of great interest to the delegates and added much to the success of the meeting.

The 1948 meeting will be held in Toronto on April 22-24.

MATILDA E. FITZGERALD Secretary-Treasurer, R.N.A.O.

Annual Meeting in Saskatchewan

On May 29-30, 1947, the thirtieth annual meeting of the Registered Nurses' Association was held in Regina. There was an attendance of approximately two hundred nurses, representing twenty-seven different centres in the province, and seven visitors from outside of Saskatchewan including one from New York. Student nurses from nine different

schools in the province were welcomed to the meeting. The response to the address of welcome was given by a charter member of the association, Mrs. W. M. Van Valkenburg, of Regina. Messages of greeting were received with applause from two other charter members: Miss Jean S. Wilson, Almonte, Ont. and Mrs. F. E. Feeny, Dearborn, Mich. The

morning session of the first day was devoted to business and meetings of three sections, in future to be standing committees.

In the afternoon Dr. H. Bucove, medical health officer, and Mrs. H. Fletcher, senior public health nurse, Health Region No. 3, gave a most enlightening presentation on "Public Health in the Health Regions." At this session members learned in detail just what is being done for the people in these regions. A delightful tea, at which the Regina and Moose Jaw Chapters were joint hostesses, followed the conclusion of the afternoon meeting. Misses Mary Brown and C. Lennie, recently elected presidents of the respective chapters, received the guests.

On Friday, special reports were presented and discussed. An innovation at the meeting was the presentation of reports from chapters. They contained many varied and interesting items such as: Parcels for nurses in Holland and Great Britain, a responsibility which has been readily assumed by chapters; contribution for Rest-Break Homes in Great Britain and assistance in bringing a delegate from Holland to the I.C.N. Congress; gifts of welcome to members of graduating classes; support of community "drives"; the establishment of a Cod Liver Oil Fund for children - in one centre 287 children have already benefitted from this; representation from the chapters on the Central Council and School

Clubs, the Film Council, etc.; assistance and furnishings to local hospitals; assistance to a crippled girl and other individuals in need. It was interesting to note that a great deal of assistance comes from the associate members, who are the so-called "inactive" (married) nurses in the community.

A film and short address on "Saskatchewan Seasons," by Fred Bard, director, Provincial Museum, brought a most fascinating glimpse of flowers and animal life in this prairie province. A presentation by student nurses, under the guidance of Miss Lucy Willis, was one of the most popular contributions on the program. During this panel discussion, four aspects of a nurse's development during the course were presented the spiritual, social, physical, and mental. Members also heard of the experiences of "Disastrous Daisy" and "Superior Susan," which portrayed in a brief sketch the reaction of these two students to their experiences as student nurses. Miss Jean Hodsdon and her committee took charge of arrangements which added so much to the success of the convention. One of the highlights was the exhibit prepared by students in schools of nursing. Miss Noreen Lambert and Miss Marguerite Palmer were in charge of arrangements.

> K. W. ELLIS Registrar, S.R.N.A.

Victorian Order of Nurses for Canada

In more ways than one, the forty-ninth annual meeting of the Victorian Order of Nurses for Canada was the most successful in the history of the Order. There were 291 delegates registered from 86 branches, an all-time high, and they came from as far west as Victoria, B.C., and as far east as Halifax, N.S. It was the final annual meeting for Miss Elizabeth Smellie, climaxing her outstanding career of twenty-three years as chief superintendent, and the highest tribute was paid to her by Her Excellency, Lady Alexander, Mr. Leonard W. Brockington, K.C., LL.D., Prime Minister W. L. Mackenzie King, who sent his tribute through the Honorable Paul Martin, Minister of National Health and Welfare, the Executive Council,

members of local boards, and the Victorian Order nurses. Everyone was sad to say farewell to Miss Smellie, but the sadness was overcome to some extent by the pleasure of hearing the announcement that Miss Maude H. Hall, who has been assistant superintendent for so many years, has been appointed the new chief superintendent. Her appointment has the whole-hearted approval of the many people who have had occasion to know her wisdom and her capable administration in the past.

One of the outstanding features was the presence, for the first time, of the general superintendent of the Queen's Institute of District Nursing, Miss E. M. Crothers, who brought greetings from the Earl of Athlone

and from the Victorian Order's "elder sisters" in Great Britain, the Queen's nurses. Miss Crothers also told the delegates something of the work of the Queen's Institute and gave praise for the work of the Victorian Order. In speaking of the shortage of nurses which is perhaps even more acute in Britain than in Canada, she said that every effort is being made to provide cars so as to make the most efficient use of the limited staff. "I am glad to see that more and more of your nurses are getting cars," she said. "I think that a nurse is far too valuable and precious a possession to have her trudging down side streets or waiting for street-cars."

The guest speakers at the various sessions included the Honorable Paul Martin, Minister of National Health and Welfare, Dr. Edward Hall, Dean of Medicine and President-elect of the University of Western Ontario, and Mr. L. Brockington, K.C., LL.D.

For the first time since before the war, the entire second day was devoted to general discussion of a number of mutual problems such as: the relationship between the board of management and the nurse; meeting increasing demands on restricted budgets; the establishment of an Educational Fund; salary schedules; uniform allowance, and so on. The discussion was lively. It served to show that there are problems that are similar in many branches and many helpful suggestions were made.

Following the close of the meeting the president, the Honorable Norman Paterson, and Mrs. Paterson entertained the delegates and the nurses at tea at their residence.

An interesting sidelight was the two enterprising delegates, from North Vancouver, B.C., who travelled across the better part of a continent to attend the meeting — and made it pay. Mrs. Chamberlain and Mrs. Johnson were the North Vancouver delegates. They bought an automobile in eastern Canada for their nurse, drove it home, and thereby saved the approximate \$250 shipping charges.

National League of Nursing Education Convention

The National League of Nursing Education extends an invitation to Canadian nurses to attend the League's fifty-first annual convention in Seattle, Washington, from September 8-11, 1947. The headquarters will be the Olympic Hotel.

The League hopes the Canadian nurses can combine a trip to Seattle for the convention with their vacations. A very interesting program has been planned and many scenic local tours have been arranged by the sub-committee on Sightseeing and Transportation so that the visiting nurses will be able to see some of the beauties of the centre of the northwest. Miss Grace Watson, chairman of this sub-committee, whose address is Washington Public Health Depart-

ment, Seattle, Wash., will supply information about local tours upon request. Any local railroad going direct to Seattle, or a connecting line, will be glad to arrange a sight-seeing tour to and from the convention. If Canadian nurses have not made their vacation plans, we hope they will include the Seattle convention in their itinerary.

For hotel accommodations they should write at once to Miss Gertie Hyptmo, chairman of the sub-committee on Housing, 514 Medical Arts Bldg., Seattle 1, Wash. Single rooms are very limited and arrangements should be made to share a twin-bedded room with a friend. The registration fee will be \$4.50 for members and guests and \$2.25 for student nurses.

Nursing Sisters' Association

At a meeting of the Executive Committee of the Ottawa Unit a report was received on the bridge and raffle held to raise money for the Rehabilitation Fund for nurses in the devastated countries which is being sponsored by the N.S.A.C. The proceeds, a

cheque for \$1000, has been forwarded to the National Association in Saint John.

The Unit recently entertained at tea at Trafalgar House, the Canadian Legion Headquarters, in honor of Miss Elizabeth Smellie, when a presentation was made.

STUDENT NURSES PAGE

My Out-Patient Experience

HELEN THOMAS

Student Nurse, School of Nursing, St. Michael's Hospital, Toronto

TO A STUDENT NURSE, the chief value of her week's observation in the Out-Patients' Clinic lies in her changed perspective of the ward In the wards, we see a patient, lying in fresh linens, comfortable, clean, being given the best of medical care and nursing service. But do we think of the home our patient has come from or of the home to which she will sooner or later return? Her routine in hospital is not ordinary-it is "extra-ordinary." Do we often forget this and, therefore, neglect to explain and teach prophylaxis and personal hygiene, and other things which seem trivialities to us, but to our patient are mountains? I think the visit of the student to the patients' homes with the St. Elizabeth nurse is a very valuable experience. Never again will I become the least bit impatient with those poor souls on the public wards, so vividly have I viewed their home conditions. Let me tell you about one of the experiences I had on my afternoon of visiting.

She was a new patient on Mrs. T's visiting list. All we knew was that she was a cardiac case, who refused to be admitted to hospital. Even the worst I expected was a far, far cry from what I saw. The home was in a poor section of the city. A shiftless Italian, the husband, housekeeper and nurse, admitted us to the two-roomed apartment. "You want to see old lady?" he asked in broken English. Then he pointed to a door and said, "In there," She

was the remnants of a once hale, hearty, happy Italian "senora." Poor. pour soul! I wish I could tell you every detail so your heart could go out in pity and kindness to her. In that room I saw the hardships and unkindness of poverty, the trial of old age and its helplessness. I felt a great desire within me at that moment to be ever very kind and gentle and patient with every patient. (Nurses, realize this - "Be kind." Remember what the patient may have come from and what she will return to. Let us make her stay in hospital pleasant. Teach patients the elements of hygiene. One can hardly visualize home conditions that exist, until one has actually had close contact with the houses in "Poverty Row.") I stood there and wondered how long it had been since the poor old senora had had her bed made - and how I should have liked to wring those filthy sheets into white sheets! She possessed no other clean bedding; no gown other than the one on her and that was ragged and dirty. To keep her warm, she had her husband's threadbare winter overcoat thrown over the bed. The room was chilly and damp. On entering, the woman received us fearfully and distrustingly. She was frightened, but the gentle manner of the St. Elizabeth visiting nurse soon won her confidence although she remained reticent all during our visit. She could speak only a word or two of English and neither she nor her husband could write. The old lady soon became grateful for our visit.

AUGUST, 1947



Oh, yes - you look sweet enough to kiss!

You're tempting, my sweet, but charm is more than smooth makeup. Why take chances of underarm odor? A bath washes away past perspiration, but Mum prevents risk of future underarm odor.

Mum

better because it's <u>Safe</u>

1. Safe for skin. No irritating crystals. Snow-white Mum is gentle, harmless to skin.

2. Safe for clothes. No harsh ingredients in Mum to rot or discolor fine fabrics.

3. Safe for charm. Mum gives sure protection against underarm odor all day or evening.

For Sanitary Napkins. — Mum is gentle, safe, dependable . . . ideal for this use, too.

Special to Public Health

A STATE OF THE STA

Nurses: Mum's Personal Grooming programme now includes "Grooming For School" charts and leaflets.

Write for your copy.

Product of Bristol-Myers Company of Canada Ltd., 3035 St. Antoine Street, Montreal 30, Que.



Curb Service. Dr. Chauncey Everitt was knocked down by a Newark, N.J. motorist. The obliging driver got out, moved Dr. Everitt off the road and drove away.

Parting Shot. Howard C. Gebhart was left \$1 in the will of his divorced wife's estate for bullets. The late Mrs. Gebhart had written, "I hope he shoots himself with one."

Attention Management. Hire a man with duodenal ulcer is Dr. Charles W. Mayo's advice when looking for a hard worker. The famous medico says an ulcer makes people high-strung and drives them to better work.

The power of advertising. Port Alberni, B.C. is the locale, and it really happened. An owner of a riding horse advertised the fact that his mount was missing. The next day the horse, bridle and all, turned up at the newspaper office. A shaken editor took charge.



"He says he got his degree at Arthur Murray."

The old man was complaining that his "old woman was too old." (Too old to live! Do we ever think that too, nurses? That's what the Nazis said—"Too old to live" and so they justified the "mercy killings." Let us be thankful that in Canada we still have "Mercy Hospital," not mercy killing. Perhaps I have diverged far from the topic but, to me, what I have just written has been my most valuable experience.)

The experience in the Out-Patients' Clinic helps the student nurse to acquire an understanding of the individual in the community, his health and social needs, and the available resources for the betterment of each. To any city, a clinic is one of its most valuable resources. It is here that the very poor come and they are given free medical care; here, too, comes the young expectant mother. To our clinic, are sent those in need of medical care in the House of Industry and the House of Providence. To the social and health services come the patients faced with difficulties and problems. A mention of but a few of these will suffice to show of what importance the settling of them is to the health and well-being of these individuals:

- 1. Carfare for transportation from outlying parts of the city to clinic.
- 2. Money to obtain glasses, dentures, or even artificial limbs.
- 3. Money for special diet foods advised by a doctor.
- The hopelessness of the young unmarried mother, who knows not where to turn in her hour of difficulty.
- 5. The need of the aged, homeless man and woman.

Yes, the social service workers are asked to work miracles, and I saw them doing it.

The knowledge and skill necessary for bedside nursing is concretely shown to the nurse during her experience here. After the patient has received the doctor's orders we must see that she understands them and knows how to carry them out. The problem may be teaching the use of insulin; instruction of the tuberculous patient in the care of himself,

and protection of his family and friends; teaching the ways of preventing the spread of venereal diseases.

The "follow-up" work done in the clinics by the health service is To our chest clinic any excellent. patient can come regardless of his financial position. If the findings are negative, the patient is relieved of his fear and apprehension. contacts of those found positive are located and requested to come to clinic for examination. Thus the spread of tuberculosis is being arrested. A close follow-up is carried out in our special clinic — if a man or woman fails to report after two warnings, a district nurse may be asked to call at the home. In all clinics one meets and observes not only future patients, but also those not requiring hospitalization.

Here one learns to recognize the problems arising out of hospitalization, particularly during our visits to the wards with the health service For the patient anxious about her children, left uncared for, the health nurse arranges for their placement in boarding homes, or the services of a visiting home mother. How these patients confide in and rely on the health service nurse! I watched them as they told their troubles to her, and I marvelled at how broad and strong her shoulders must be to share and solve the problems of so many.

By no means the least important is the link between patient and hospital before and after admission — for example, the postnatal and prenatal clinics. Regular attendance at prenatal clinics ensures the expectant mother of the necessary medical attention by which any complications may be detected and treated. As well, the mother-to-be receives invaluable instructions applicable to this or subsequent pregnancies. Following her discharge from hospital, the mother visits postnatal clinics and a visiting nurse may be asked to call on her at home. Our clinics make possible expert medical attention to less fortunate patients in their own

Our Out-Patient Department is the acme of co-ordination. A patient will see a medical doctor, who may refer him to the diabetic clinic from which he may be referred to the eye clinic — and all for thirty-five

cents, if the patient has it, and all for nothing if he hasn't. Do you ask me my impression of the Out-Patients'? It seems almost like a blessed work of charity, answering the question "Who is my neighbor?"

Book Reviews

Introduction to Psychobiology and Psychiatry, by Esther Loring Richards, M.D., Sc.D. 419 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1946. Price \$3.75.

Reviewed by Edith Pullan. Instructions.

Reviewed by Edith Pullan, Instructress, Provincial Mental Hospital, Essondale, B.C.

The understanding of human behavior, particularly its many abnormalities, is stressed by Dr. Richards. The psychobiological aspect is used in the approach to the subject of psychiatry. The use of this approach provides considerably more meaning to an abstract subject.

The arrangement of the contents of the book facilitates clear-cut thinking and organization of subject matter into more easily remembered groupings. This organization is advantageous in a textbook which is designed for use by students.

The text is divided into four main sections. The first is devoted to a discussion of human behavior. Here the historical background of man's study of man is sketched, with the emphasis placed on the important factors of normal human behavior and the methods of investigation of personality. The author points out their uses in the field of nursing. Part Two deals with the fundamentals of psychiatric work, the historical review, factgathering, and some objectives in psychiatric nursing. Part Three gives an adequate and comprehensive discourse on mental defectiveness, neuroses, and major psychoses. Part Four is in the form of an appendix, which gathers together much useful information, such as psychobiological terminology, therapeutic techniques. The grouping together of information such as this provides easy accessibility.

This book is designed for students to give them an understanding of psychiatry as well as human behavior, the knowledge of which is essential to all nurses. It is well organized and contains many short, well-synopsized case histories which adequately illustrate the various psychiatric conditions.

Nutrition and Diet Therapy, a Textbook of Dietetics, by Fairfax T. Proudfit and Corinne H. Robinson. 782 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 9th Ed. 1946. Illustrated, Price \$3.75.

Reviewed by Sister M. Josephine, B.H.Sc., Dietitian, St. Elizabeth's Hospital, Humboldt, Sask.

Anyone interested in nutrition and diet will find this new edition interesting and stimulating. The authors write in an easy, simple, yet interesting style. The briefness and conciseness of this new edition is to be admired. The section on diet therapy is particularly succinct and condensed. The shorter and less extensive volume has not lost any instructive value through the omission of some detail. The combining of certain chapters and the omission of charts and lengthy summaries has eliminated much repetition. This volume has compressed an amazing amount of information.

The ninth edition of this well-known and widely used text presents only a few, yet long looked for and timely changes. The change in the order of presentation of food constituents is, indeed, a most logical one. An intelligent comprehension of energy metabolism necessitates a preceding explanation of the food constituents. The arrangement is like putting the cart in front of the horse or, as the authors state in the preface of this book,—"It is like buying the combustion engine before being concerned about the fuel which the engine will burn."

The inclusion of the chapters on Safeguarding Food Supply, Feeding the Aged, and the tables giving the normal constituents of the blood and urine as well as the health



AUGUST, 1947



- An OPPORTUNITY
- A CHALLENGE
 60 Graduate Nurses
 for Indian Hospital
 and Field Duty

Expansion of modern hospital and public health services to Canada's Indians requires additional nurses to meet the challenge of this humanitarian work.

Vacancies

Brantford Norway House
Manitoulin Island Battleford
Port Arthur Qu'Appelle
Kenora Edmonton
Winnipeg Prince Rupert
Sioux Lookout Nanaimo
Sardis

Salary:

Up to \$167 per month, less maintenance if provided. Extra salary for operating room, night supervisor and public health nurses.

Write to:

MR. J. C. RUTLEDGE,
Department of National Health and
Welfare,
Birks Bldg., Ottawa, Ont.

past. When accidentally mixed with food or drink, it has been the cause of a number of deaths. Several years ago, four infants died from boric solution which had been mistaken for sterile water. Following several such tragedies, many hospitals have removed this drug from use.

Where boric acid solution is still used in various ways, especially to cleanse the nipple prior to breast feeding, specific orders should be obtained from the doctor, clinic, or hospital for its use. If the solution is ordered for any purpose, the nurse has a responsibility to see that the mother understands its dangers, and has the container labeled and out of reach of small hands. To be even moderately effective, the solution must be prepared fresh daily with sterile water and kept in a sterile container.

Free Automobiles

Approximately 13,790 Canadian veterans of World War II who lost, or lost the use of, one or both legs have been certified as eligible to receive automobiles or other conveyances at government expense, Veterans Administration announced.

Ontario

The following are staff appointments to and resignations from the Ontario Public Health Nursing Service:

Appointments: Irene Weirs (Wellesley Hospital, Toronto, and University of Toronto School of Nursing) as supervisor, public health nursing, with newly-formed health unit in Counties of Leeds and Grenville; Phyllis Thomson (Harper Hospital, Detroit and Universities of Toronto and Western Ontario) as supervisor, public health nursing, with newly-formed Kent County health unit; Reta Sutcliffe (Hospital for Sick Children, Toronto, and McGill School for Graduate Nurses) as supervisor, public health nursing, with newly-formed Halton County health unit; Margaret MacLachlan (B.Sc.N., University of Toronto) as senior public health nurse with Simcoe County school health service after a year's leave of absence taking post-graduate study at the University of Toronto; Mrs. Margaret Jewell (St. Michael's Hospital, Toronto, and University

of Toronto certificate course), formerly senior public health nurse with Leaside Board of Health, to Brant County health unit: Katharine Forbes (Toronto Western Hospital and University of Toronto certificate course), formerly with United Counties health unit, to Ottawa Collegiate Board nursing staff: Alice Macklin (Victoria Hospital, London, and University of Western Ontario certificate course) to Elgin-St. Thomas health unit; Kathleen Abbott (Wellesley Hospital, Toronto, and University of Toronto certificate course), previously with Simcoe County school health service, to Leeds and Grenville health unit; Fernande Lefaive (St. Joseph's Hospital, London, and University of Western Ontario certificate course), formerly with Prescott and Russell health unit, as public health nurse with newly-formed service in the Township of Sandwich West; Mary Pae (Montreal General Hospital and University of Toronto certificate course) to Brant County health unit.

Resignations: Janet Burnett (Hamilton General Hospital and University of Toronto certificate course) as acting senior public health nurse in Simcoe County; DorothyMc-Kerracher (Royal Victoria Hospital, Montreal, and University of Western Ontario certificate course) from East York-Leaside health unit; Evelyn Walker (Woodstock General Hospital and University of Toronto certificate course) from Oshawa Board of Health.

News Notes

ALBERTA

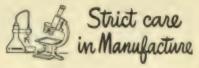
Calgary General Hospital:

Miss Marion Moodie, of Montreal, first graduate of this school of nursing, was a recent visitor at the hospital and guest speaker at the June meeting of the alumnae association. Miss Moodie, who graduated in 1898, holds the distinction of being the first trained nurse in Alberta.

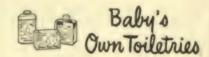
Going back to the days when the hospital consisted of a wooden frame building with its doors marked with bullet holes, she told of many experiences. Wearing her hospital pin, with which she was presented upon completion of her training, she told of the first simple service when she was given her diploma in the presence of several members of the hospital board, a minister, and two doctors. After doing considerable private duty in Calgary, Miss Moodie joined the staff of the hospital at Frank, Alberta, and later proceeded to the Ninette Sanato-

Pure, Safe ingredients...

75 years of experience and research have made Baby's Own Soap, Oil and Powder completely safe and soothing for even the most sensitive skin tissues.



Close inspection and careful control ensure absolute hygiene at every stage of manufacture . . . compounding, handling and packaging.



Baby's Own products have won the confidence and trust of so many members of the medical profession that you may recommend these toiletries for the care of any baby with complete certainty.

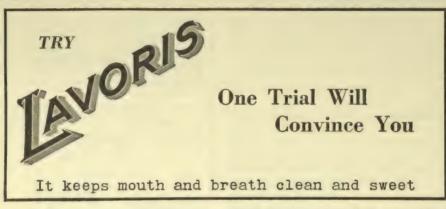


The J. B. WILLIAMS CO. (CANADA) LIMITED

La Salle, Montreal

DIRECTOR-in-CHIEF OF NURSING SERVICES WANTED

Applications are invited for the position of Director-in-Chief of Nursing Services, Victoria Hospital, London, Ont., Canada. The position, vacant on February 1, 1948, is one of the best in the nursing field and includes the over-all directorship of the entire hospital nursing service and the correlation of the work of three existing major positions: (1) Director of Nurse Education: (2) Director of Nursing Service at the nearby affiliated War Memorial Children's Hospital; (3) Director of Nursing Service at Victoria Hospital; all of which are responsible for the educational program and training of 200 student nurses, and the nursing service of 125 graduates. Total bed capacity, 575, which will be increased to 750 beds within 3 years. Teaching hospital; University medical centre. Applicants must have university degree or equivalent in post-graduate nursing education and with experience in hospital nursing administration. Personal interview will be arranged. Apply by letter to The Medical Superintendent.



rium, Man. She has done considerable writing and one of her better know poetic works is the book, "Songs of the West and Other Poems."

BRITISH COLUMBIA

CHILLIWACK:

Over \$140 was realized from the tea and display of arts and handicrafts recently sponsored by Chilliwack Chapter, R.N.A.B.C. The funds will be used to send food parcels to nurses in European countries and the British Isles, to help equip libraries in schools of nursing in devastated countries, and to build up the local Special Nurses' Fund. The president, Constance Bratrud, and A. MacKay, immediate past president, received the 250 guests. Members of the Chilliwack Hospital staff assisted in serving.

At the June dinner meeting of the chapter, Lyle Creelman, formerly with UNRRA, gave an interesting account of her experiences, illustrating her talk with colored slides.

ROSSLAND:

Eleven members were present at a recent meeting of Rossland Chapter, R.N.A.B.C., when Nan Kennedy presided. Dr. E. E. Topliff, the guest speaker, gave an informative address on the new drugs and also discussed the new hospitalization scheme and explained how it was effectively carried out in England. Refreshments were served by Mmes W. Roper and W. C. Stevens.

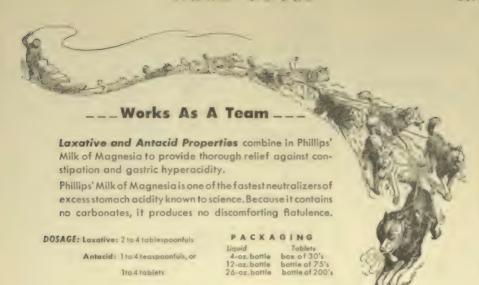
At the last meeting of the season Mrs. R. McAllister gave a report on the home nursing classes, stating that twenty-four had taken the course. Flora McLean, who attended the I.C.N. Congress, revealed that thirty-three countries were represented.

MANITOBA

St. Boniface Hospital:

A well-attended spring tea and sale of home cooking was held in April when Mrs. R. F. McWilliams, wife of the Lieut.-Governor of Manitoba, presided at the opening. The guests were received by the superior, Sr. Boisvert, the superintendent of nurses, Sr. Jarbeau, and Mary Wilson, president of the alumnae association. The proceeds went towards a \$150 scholarship for a member of the 1947 graduating class for post-graduate study, and to maintain the Loan Fund, which is available to any qualified alumnae for that purpose.

Forty-nine graduates received their diplomas at the 1947 exercises, when they heard addresses by His Grace, The Archbishop of St. Boniface, and Dr. J. D. Adamson. Patricia Houston was valedictorian. Emily Zanyk won the alumnae scholarship and will take post-graduate work in public health nursing. The scholarship donated by the hospital was won by Pierrette Boucher who will take pediatric nursing. The alumnae entertained the graduating class at a dance which was much enjoyed. The patrons were Dr. and



PHILLIPS' Milk of Magnesia

PREPARED ONLY BY THE CHAS. H. PHILLIPS CO. DIVISION OF STERLING DRUG INC. . 1019 ELLIOTT STREET, WEST, WINDSOR, ONT.

Mrs. P. H. McNulty, Dr. and Mrs. M. Rady, Dr. and Mrs. D. S. McEwen, and Dr. and Mrs. R. Burrell. The convener for this successful event was C. Bourgeault.

Mrs. A. P. Johannson, wife of the Icelandic

Mrs. A. P. Johannson, wife of the Icelandic Consul, was guest speaker at a recent alumnae meeting when she told of her trip to Iceland

and the conditions there.

SELKIRK:

Mrs. H. Henrikson, president of Selkirk Branch, M.A.R.N., was in the chair at a recent meeting when Miss Margaret E. Kerr, editor of The Canadian Nurse, was guest speaker. The meeting was in the home of Mrs. W. F. Langrill. Introduced by Mrs. R. B. Carpenter, Miss Kerr gave a brief outline on the founding of the Journal and the preparation of each issue prior to publication. Mrs. C. Kershaw thanked the speaker. Katherine Barr, convener of the Journal for the M.A.R.N., accompanied Miss Kerr from Winnipeg.

Winnipeg General Hospital:

The month of May saw the celebration of the 60th Anniversary of the Winnipeg General Hospital School of Nursing. Registration of former graduates, from all parts of Canada and many from the United States, took place at Marlborough Hotel with Mrs. Rex Waldie, chairman of the Anniversary Celebration Committee of the alumnae association, in charge. This was followed by a reception at the nurses' residence, given by the president and Board of Directors of the hospital. Over 420 nurses attended the dinner, held

at Fort Garry Hotel, when the Mayor and Council of the City of Winnipeg honored the graduates. Dr. Charlotte Whitton spoke on "Nursing and the Challenge of Social Change," paying tribute to the fine service rendered by the hospital to the community and to nursing. The speaker was thanked by Alderman Hilda Hesson.

Mayor Garnet Coulter, in welcoming the nurses and guests, spoke of the pride Winnipeggers have in the W.G.H. and felt it fitting the city should recognize its alumnae. Miss Lynette Gunn, the alumnae's president, responding to Mayor Coulter's remarks, told of the first graduating class in 1889, and of succeeding classes who have practised their profession all over the world.

NEW BRUNSWICK

BATHURST:

Five nurses received their diplomas and pins at the graduation exercises of the Hotel-Dieu. This was the third class to be graduated. At the same time B. Chamberlain was award-

ed a nurses' aide certificate.

The ceremonies began with mass by Rt. Rev. Msgr. A. J. Trudel with the sermon preached by Rev. J. A. Arseneau. Dr. D. A. Thompson presided over the evening exercises when he addressed the new graduates. Dr. George Dumont, Campbellton surgeon, also spoke in French, when he rendered homage to the Religious Hospitallers of St. Joseph. Dr. L. D. Densmore, dean of active medical staff of Bathurst, extended his best



THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing, with or without experience.

Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Miss Maude H. Hall Chief Superintendent 114 Wellington Street Ottawa. wishes to the nurses. The closing address was given by Msgr. D. Robichaud.

FREDERICTON:

Sixty-one nurses were present at the closing dinner meeting of the season held by the Fredericton Chapter, N.B.A.R.N., at D-Coy Inn. The tables were centred with bowls of tulips, the gift of Mrs. Belmore. Seated at the head table were Mrs. S. M. Rankine, immediate past president and guest of honor, Shirley Grant, president, Audrey Charters, secretary, and Edith Warman, treasurer.

During the business meeting the president welcomed a number of former members who were visiting the city, including Mrs. E. (Ross) Currie, of Montreal, Mrs. R. (Daley) Prinoe, of Toronto, and Mrs. H. (Estabrooks) Sinnett, of Newcastle. Isobel Lane gave an interesting account of the executive council meeting and Dorothy Parsons gave her impressions of the I.C.N. Congress. Mrs. C. Simms, on behalf of the members, presented Mrs. Rankine, who is leaving for Halifax, with a gift of china and a beautiful nosegay with words of appreciation for her leadership within the association.

Victoria Public Hospital:

Leta Gordon, after taking a post-graduate course at the Homoeopathic Hospital, Montreal, is now supervisor, central supply department. Other additions to the staff include Eileen Tracey, Doris Crawford, and Norma Smalley.

SAINT JOHN:

The 1947 graduating exercises of the Saint John General Hospital were honored by the presence of Lieut.-Gov. and Mrs D. L. MacLaren who extended congratulations and good wishes to the new graduates and paid tribute to the hospital and its capable staff. Also in attendance were about one hundred nurses from the other Saint John hospitals.

Dr. W. O. McDonald, in his address to the graduates, reminded them that their thoughts were more important than their actions as actions were the result of thoughts. Sonia A. Black delivered the valedictory and Rabbi A. N. Oler offered the invocatory prayer and led the graduates in repeating the Nightingale Pledge.

Prizes were awarded as follows: Ellen Cunningham, Medical Association award for highest standing in the three years' course; Sonia Black, Hospital Alumnae's award for highest standing in junior division and the Ella McGaffigan prize for general proficiency, as well as the Hospital Aid's award for junior obstetrics; Alda R. Britton, Hospital Aid's award for senior obstetrics; Jeanette MacWilliam, highest standing in surgery.

William, highest standing in surgery.

The superintendent of nurses, Margaret Murdoch, assisted J. F. H. Teed, K.C., vice-president of the board of commissioners of the hospital, in the presentation of certificates

and pins.

Beatrice Selfridge presided at the dinner dance and bridge held by the alumnae association in honor of the fifty graduates of the 1947 class. Miss Selfridge gave the welcom-

Hands constantly in water need NIVEA



Because a nurse's hands are so frequently in contact with water and antisepties the skin is quickly deprived of its natural moist and oily secretions. It then becomes heard day, and seeks. Nines

secretions. It then becomes hard, dry and scaly. Nivea Creme is made specially to replace these nourishing elements of the skin. It is a water-in-oil emollient containing Eucerite—a substance closely resembling the skin's natural oils. Aided by Eucerite, Nivea penetrates right into the underlying tissues and nourishes the skin. Use Nivea Creme for your own and your patients' skin care. For massage, or for very dry skins, use Nivea Skin Oil.

Skin needs NIVEA

FOR SKIN-HEALTH AND BEAUTY

'Nirea' and 'Eucerite' are registered Trade Marks

C.30

Manufactured in Canada by NIVEA PHARMACEUTICALS LIMITED

Instributing Agents
VANZANT & COMPANY
857 College Street, Toronto

ing address with Alda Britton responding. Evelyn Greene rendered two solos, while Marjorie Clark lead in a sing-song accompanied by Alberta Hanscome.

panied by Alberta Hanscome.

Doris Butler has joined the operatingroom staff. Mrs. (Armour) Coffins has moved
to Montreal while Mrs. (Black) Rankine is

now in Halifax.

NOVA SCOTIA

KENTVILLE:

A recent meeting of Valley Branch, R.N. A.N.S., took the form of a picnic supper and ball game held at the Experimental Farm. Later in the evening, Margaret E. Kerr, editor of *The Canadian Nurse*, gave an interesting talk on her work. An excellent report on the R.N.A.N.S. annual meeting was presented by Mrs. C. R. Armiston.

ONTARIO

DISTRICTS 2 AND 3

OWEN SOUND:

One hundred and ten members registered for a recent meeting of Districts 2 and 3, R.N.A.O. Dr. Bruce Hallett gave the invocation and Dr. Jack Middleborough also brough greetings. Reports of the R.N.A.O. and I.C.N. Congress were given by Marion Patterson and Dora Arnold. Other interesting items included an address by Rev. Harold Vaughn, M.A., Th.D., on "Religious Therapy" and colored motion pictures depicting a trip "Through the Canadian Rockies" by Dr. A. D. Pollock. Violin and piano solos

by Macey Codesky and Miss McRoberts, a student nurse, were greatly enjoyed.

A wonderful supper served under the auspices of the General and Marine Hospital Alumnae Association and a boat trip on Owen Sound Bay ended a perfect day.

KITCHENER:

Highlights of the I.C.N. Congress were given by a Scottish nurse at a recent meeting of Kitchener Chapter, Districts 2 and 3, R.N.A.O. Mary Schlichter presided. The speaker was Dorothy Patterson, superintendent of a children's hospital in Ayr, Scotland, who was introduced by Sylvia Hallman. Speaking with a rich broque and much humor, Miss Patterson gave her impressions of America and Canada. Discussing food conditions in Scotland, she said that, at her hospital, butter and sugar were not rationed out individually. They were placed on the table and used till gone. A brief talk was also given by Olga Friesen, who recently returned after serving with UNRRA in Germany.

Stratford General Hospital:

The Stratford General Hospital Alumnae Association gave a dinner for the nineteen members of the 1947 graduating class when a prize was donated for proficiency in obstetrics.

A successful rummage sale was held and plans are being made for another one in the fall. Parcels have been sent every two months to nurses in Britain.

REGISTERED NURSES' ASSOC'N. OF BRITISH COLUMBIA

Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director Placement Service

1001 Vancouver Block, Vancouver B.C.

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

To take place on October 15, 16, and 17, 1947, at Halifax, Yarmouth, Amherst, Sydney, and New Glasgow. Requests for application forms should be made at once, and forms MUST BE shound be made at once, and rolls by September 15, 1947, together with: (1) Birth Certificate; (2) Provincial Grade XI Pass Certificate; (3) Diploma of School of Nursing; (4) Fee of \$10.00.

No undergraduate may write unless he or she has passed successfully all final School of Nursing examinations, and is within six weeks of completion of the course of Nursing.

NANCY H. WATSON, R.N., Registrar The Registered Nurses' Association of Nova Scotia 301 Barrington St., Halifax, N.S.

Stuffy Nostrils



Stuffy, mucus-choked nostrils nostrils ...blocked nasal passages ... can't breathe properly ... sleep broken.. try Mentholatum for instant relief. Jars and tubes, V-10

DISTRICT 4

NIAGARA FALLS:

The North Pavilion in Queen Victoria Park was the scene of a delightful picnic tea in honor of thirty delegates from other countries who attended the I.C.N. Congress. District 4, R.N.A.O., were responsible for arrangements and the guests were received by the chairman, Anna Oram, and Anne Blackwood and Catharine O'Farrell, presidents of the Hamilton and Niagara Peninsula Chapters. Tea followed a sight-seeing trip from Toronto to Niagara-on-the-Lake and Chippawa and later the party gathered to hear Mr. George Hamilton speak on "The Niagara Park Frontier," when colored motion pictures were also shown. Mrs. L. Lynn, Dean of Nursing, Medical College of Nurses, Shanghai, China, expressed the thanks of the visitors, most of whom then viewed the illumination of the Falls.

DISTRICT 5

At a general meeting of District 5, R.N. A.O., held in Oshawa, about 130 members were in attendance. Jessie Wallace presided. A panel of the Hamilton convention was presented by the first vice-chairman and three section conveners. Miss Wallace, as representative to the I.C.N. Congress, brought an

informative report from Atlantic City.
Mr. Marshall Close, salesman for the Toronto Lithograph Company, and an associate with C. W. Wright as speech instructor, was guest speaker at the evening session. Through his topic, "To Whom Shall the Nation Look," he urged that Canadians get to know more about Canada, speak well about it, and take more interest in the science of our government. M. Bourne, superintendent of the Oshawa General Hospital, thanked the speaker.

Collingwood:

Alice Young, who has been director of nursing education at the General and Marine Hospital for the past four years, recently resigned. In her honor a reception was held by the graduate staff and student body and also attended by the board of directors and their wives. A series of presentations were made when Miss Young was the recipient of a morocco case of surgical instruments from the board, a camera from the graduate staff, a pen and pencil set from the students, and a photo album from the office staff. Speaking for the board, Mr. J. L. Smart, Miss Lund, superintendent, and Miss Robinson, on behalf of the student nurses, all expressed regret at losing the services of Miss Young.

Beatrice Welsh was also hostess at her home for Miss Young when forty guests were present. Assisting with the serving of refreshments were Mmes F. J. VanNest, J. A. Ditson, Lloyd White, Misses MacLaren

and C. Shipley.

QUEBEC

QUEBEC CITY:

The Chateau Frontenac was the scene of the annual dinner given by the Jeffery Hale's Hospital Alumnae Association for the 1947 graduating class. G. Weary proposed the toast to the King while M. Dawson did the honors for the Alma Mater and M. E. Lunam for the new graduates. H. MacLean gave the response for the 1947 class and N. Humphries proposed the toast to "Absent Friends. An imaginative class prophecy was written

and presented by D. Rourke and piano selections were rendered by Mr. W. H. Ross.

Thirteen graduates received their diplomas at the exercises held the next evening. The Governors' prizes were awarded to Mrs. Travers and Jean MacTavish and D. Rourke won the Women's Auxiliary prize. The Rev. W. W. Davis, B.A., B.D., was the guest speaker for the evening and an added pleasure was the presence of Miss Gordon from England who also spoke to the graduates and guests. The Rev. H.S.B. Harper pronounced the invocation and benediction.

An enjoyable formal dance was a highlight of graduation week when graduates and guests gathered in the lounge of the nurses' residence.

Jeffery Hale's had the honor and privilege of entertaining several visiting nurses from England and the Continent who came on to Canada after attending the I.C.N. Congress.

SASKATCHEWAN

ESTEVAN:

A. Ducluzeau has returned to her position on the O. R. staff of St. Joseph's Hospital after an extended vacation in France and the French Morocco. C. Bonokoski and I. Schewgman are now on the staff of St. Joseph's Hospital and Extension respectively.

REGINA:

The newly-elected executive for Regina Chapter, S.R.N.A., consists of: Honorary president, Rev. Sr. A. Brodeur; president, Mary Brown; vice-presidents, M. Palmer and Mrs. M. Davey; secretary-treasurer and assistant, Mrs. E. Parker and E. Metz.

A successful Lilac Tea, for the nurses'

A successful Lilac Tea, for the nurses' registry, was held at the home of Mrs. J. Brown. Mrs. Brown and Mary Brown, the chapter president, received the eight hundred guests.

General Hospital:

Sixty-one nurses received their diplomas and pins at the 44th graduating exercises of the Regina General Hospital. Agnes Swanseid, a 1946 graduate, received a Carss Scholarship for a one-year university course.

A miscellaneous double shower was held in honor of E. Aldridge and B. Patterson who are leaving the staff to be married. Miss Aldridge has been science instructor for three years while Miss Patterson was head nurse on Ward I. E. L. Hennigar and L. E. Garland, who have completed a course in teaching and supervision at the University of Manitoba, are on the staff. Recent resignations include I. M. Ficke (Ward J) who has been called to the mission field.

Grev Nuns' Hospital:

Dr. and Mrs. Rennick and Dr. and Mrs. Ring were patrons and patronnesses for a dance given by the graduating class and an enjoyable dance was also given by the student body.

P. Graham is leaving the staff to take a teaching and supervision course at the



Good As Gold

What a difference from the fretty, feverish, restless baby who worried Mother such a short time ago! Yes, for the quick relief of constipation, digestive upsets, teething troubles and other minor ailments, Baby's Own Tablets are proving their effectiveness daily in thousands of homes—as they have for over half a century. If desired they may be easily crushed to a powder, and, as they contain no narcotics, opiates or toxic ingredients may be administered with entire confidence.

BABY'S OWN



THE ART AND SCIENCE OF NURSING

By Ella L. Rothweiler and Jean Martin White. This widely used textbook continues to grow steadily in popularity. It consists of 10 well-planned units with special material on hydrotherapy, first aid, blood and plasma banks and the iron lung. 793 pages. 145 illustrations. Eleventh printing 1945. \$4.00.

PRINCIPLES OF PEDIATRICS AND PEDIATRIC NURSING

By Cecilia M. Knox. This book, consisting of 15 units, is conceined with the child in bath health and disease, with total behaviour and development physical, mental, social and emotional, 5.17 pages 65 illustrations 1945 \$4 00.

THE RYERSON PRESS

TORONTO

DYSPNE INHAL

For OUICK relief of

AsthmaticAttacks, Emphysema, Hay Fever, Dyspnoea and Respiratory Embarrassment.

For inhalation only

SAFE and ECONOMICAL TREATMENT

ROUGIER FRÉRES

350 LeMoyne St.,

Montreal 1, P. Q.

WANTED **PUBLIC HEALTH NURSES**

for

Welland and District Health Unit Minimum Salary: \$1,700 Regular Holidays with Pay

Apply in writing to:

J. D. WATT, Secretary 120 King St., Welland, Ont.

THE ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

The 1947 Fall examinations for provincial registration will cover two groups of candidates and will be held as follows:

GROUP A: Graduates qualifying for the licence to practise will write in Montreal, Quebec, and Sherbrooke on November 17, 18, and 19, 1947. Candidates will not be permitted to write these examinations until they have actually finished their training and hold the diploma of their School.

GROUP B: Students who will have completed their first year before October 1, 1947, will enter the preliminary test covering oral, prac-tical and written, which will be held on October 6, 7, 8, and 9, 1947. (Time to be announced in each school.)

For application forms and all information relating to the examinations apply to the head-quarters of the Association.

Applications for preliminaries must be received by September 15, 1947, and for finals by October 15, 1947.

E. FRANCES UPTON, R.N. Secretary-Registrar 506 Medical Arts Bldg. Montreal 25, P.Q.

University of Manitoba. P. Evans, assistant supervisor on 3C, and I. Wallwin, of the central dressing room, are leaving to be married.

SASKATOON:

Graduates from the University of Saskatchewan, with degrees in nursing, were D. James, M. Newsham, L. Selchen, N. Simpson, D. Tollerud, and W. Nicol. Miss Newsham graduated with distinction and was awarded the University Scholarship.

City Hospital:

Forty-seven nurses received their diplomas and pins at the exercises held by the Saskatoon City Hospital. The new graduates were guests of the board of governors of the hospital and the Student Nurses' Association at a formal dance.

The nurses of the hospital took part in the Tag Day sponsored by the Women's Hospital Auxiliary. Mr. George Porteous was guest speaker at a recent alumnae meeting when he gave an account of life in a Hong Kong concentration camp.

Mrs. E. Flack is now on the staff and J. Bingham, who has done post-graduate work in Rochester, N.Y., in E.E.N.T., is on the O.R. staff. H. Brayford is now studying nursing of cancer patients in New York. J. Watters and M. Cawsey, who have received scholarships, are taking pediatrics at Children's Memorial Hospital, Montreal. M. Reid is on leave of absence from Shaughnessy Hospital, Vancouver, to take tuberculosis nursing at Hamilton.

St. Paul's Hospital:

Mrs. James (Hayes) Grace, of Detroit, recently visited the hospital and school of nursing.

YORKTON:

Fourteen nurses were graduated at the Yorkton General Hospital exercises. The 1947 class were entertained at a banquet by the alumnae association and a dance was also held for them by the Yorkton Chapter.

BERMUDA

Thirty-four members attended the recent formal dinner given by the King Edward VII Memorial Hospital Alumnae Association. This was in honor of fifteen young graduates -five of last year's class and ten of the 1947 class. The guest speaker was Mrs. Albert (Barnfield) Spurling, who was matron of the hospital for three years. She was introduced by Elic Outschrides the duced by Elsie Outerbridge, the present matron, and thanked by Minna Smith. Mrs. Spurling spoke of her experiences during her term of administration and also mentioned her visit to the New York Hospital, her alma mater, for the 70th anniversary of their alumnae association.

The president, Mrs. John Nunan, awarded a prize to Rebecca Dew for gaining a place on the honor list in the Registration Exam-

inations in Quebec.

Positions Vacant

Superintendent of Nurses. Splendid opportunity to become associated with active Anti-Tuberculosis program, treatment, and rehabilitation. Pension plan, sickness and hospitalization insurance available to staff. Apply, stating experience in administration and tuberculosis nursing, and salary expected, to Medical Supt., Freeport Sanatorium, Kitchener, Ont.

Assistant Superintendent of Nurses and Director of Nurse Training for 500-bed hospital in Central Canada. Initial gross salary: \$2,400 per year. Apply in care of Box 6, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, P.Q.

Public Health Nurses for City of Kingston. Salary: \$1,500 to \$1,800 depending on experience, with annual increments to \$1,800 maximum. Superannuation. Generalized service. University city. Apply, stating qualifications and references, to Mr. C. C. Wyatt, Sec., Board of Health, Kingston, Ont.

Provincial District Nurses in Province of Alberta. Districts located in rural areas. Cottage, water, and fuel supplied by community. Salary: \$1,920 to \$2,400 per annum. Sick leave. Annual vacation provided after 1 year's service. For further information apply to Miss Jean S. Clark, Director, Division of Public Health Nursing, 218 Administration Bldg., Edmonton, Alta.

General Duty Nurses immediately. 8-hour day and 6-day week. Salary: \$125 per month plus full maintenance; \$30 bonus after first 6 months and \$60 bonus after 12 full months' service. 3 weeks' holiday after 1 year's service. Fare from Edmonton refunded after 6 months. Modern nurses' home. Apply to Miss J. A. Ross, Matron, Municipal Hospital, Grande Prairie, Alta.

General Duty Nurses for Operating-Room, Emergency and Out-Patient Dept. Bed capacity, 575. Good salary and Cost of Living Bonus. Splendid opportunity for experience. Post-graduate and practical experience very desirable. Also General Duty Nurses for various depts, with opportunity for advancement. Apply, stating school, and year of graduation, age, details of experience, and date of availability for service, to Supt. of Nurses, Victoria Hospital, London, Ont.

Graduate Nurses (3) for hospital in Peace River country. Salary: \$125 per month plus full maintenance. Apply to M. F. Malkinson, Sec. Treas., Community Hospital, Fairview, Alta.

Supervisor and General Duty Nurse for small private hospital 60 miles from Montreal. Medicine, surgery and obstetrics. Apply, stating age, graduation, if bilingual, etc., to Dr. Kelly's Hospital, Hawkesbury, Ont.

General Duty Nurses for new 26-bed hospital. Salary: \$110 per month with full maintenance. After 1 year's service, 1 month sick time with pay and tree hospitalization. 2 weeks' holiday with pay. 8-hour day (7-3, 3-11, 11-7); 6-day week. No night duty except odd night of relieving. Town situated 47 miles north of Calgary on main C.P.R. line between Edmonton and Calgary with 3 trains each way every day. Good bus service. Only 80 miles from Banff National Park. 5 General Duty Nurses employed. Apply to Municipal Hospital, Didsbury, Alta.

Instructor in Nursing. State qualifications and salary expected. General Staff Nurses. Salary, \$110 per month plus maintenance. Excellent living conditions and recreational facilities. Apply to Director of Nursing, Verdun Protestant Hospital, Verdun, Montreal 19, P.Q.

Operating-Room Charge Nurse for 80-bed hospital. Post-graduate experience preferred. Full maintenance provided; hospitalization; sick leave; holidays with pay. Apply, stating salary expected, qualifications, and date available, to Supt., Norfolk General Hospital, Simcoe, Ont.

Public Health Nurse immediately for rural work for Elgin-St. Thomas Health Unit. Salary: \$1,500 a year according to experience. Car allowance, \$550 a year. Assistance in our purchase can be arranged if required. Apply to Supervisor of Nurses, City Hall, St. Thomas, Ont.

AUGUST, 1947

Nurse for charge of Operating-Room in 60-bed hospital. Apply, stating salary expected, to Supt., Great War Memorial Hospital, Perth, Ont.

Registered Nurse for Community Hospital where excellent salaries are paid. Living accommodation provided. For particulars write to Dr. H. R. Clouston, Supt., County Hospital, Huntingdon, P.Q.

Graduate Nurses (2) for **General Duty** immediately. Salary: \$110 per month with full maintenance. 8-hour day and 6-day week. 50 cents an hour for overtime. Apply to Little Bow Municipal Hospital No. 25, Carmangay, Alta.

Superintendent for active 20-bed hospital. Good salary and working conditions. Apply stating qualifications, to Chairman, Hospital Board, Palmerston, Ont.

Nursing Arts Instructor. Dietitian. Assistant to Night Supervisor. General Duty Nurses. For 250-bed General Hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, General Hospital, Brandon, Man.

Nursing Arts Instructor and Science Instructor. Psychiatric experience preferable but not essential. Apply, stating qualifications, experience, salary expected, and date of availability, to Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Instructor of Nurses. Salary: \$140 per month and full maintenance. Dietitian. Salary: \$130 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Instructor of Nurses (qualified). Duties to commence September 1. Apply to Supt., City Hospital, Sydney, N.S.

Clinical Supervisor for 250-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt. of Nurses, McKellar Hospital, Fort William, Ont.

Obstetrical Supervisor for Royal Columbian Hospital, New Westminster, B.C. State qualifications, experience, and date of graduation in first letter. Apply to Supt.

Registered Nurses for General Staff Nursing in Medical, Surgical, and Obstetrical Depts. Operating-Room Nurse and Assistant Night Supervisor. For 100-bed General Hospital in Western Ontario. 8-hour day and 48-hour week. Apply, stating qualifications and salary expected, to Supt. of Nurses, General Hospital, Woodstock, Ont.

General Staff Nurses. Salary: \$140 per month living out, plus laundry. Annual increment. Operating-Room Nurses. Post-graduate course essential. Salary: \$145 living out, plus laundry. Annual increment. Accumulative sick leave. Hospitalization. Superannuation. 31 days vacation. Statutory holidays. 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Please note that investigation should be made with regard to registration in B.C. Apply to Director of Nursing, General Hospital, Vancouver, B.C.

General Staff Nurses. Initial salary: \$140 per month and laundry. First increment is granted after 6 months. 8-hour day and 6-day week. 3 weeks' annual vacation. Apply to Supt. of Nurses, General Hospital, Toronto, Ont.

General Duty Nurses for 20-bed fully modern hospital. Salary: \$120 per month and full maintenance. 6-day week. Apply to Supt. of Nurses, Municipal Hospital, Brooks, Alta.

Registered Nurses for General Duty at Haldimand War Memorial Hospital, Dunnville, Ont. Salary: \$120 per month plus full maintenance. 6-day week. Long week-end once per month (3 days). 3 week's vacation with pay. Comfortable, homey residence. Pleasant surroundings. Dunnvile (pop. 4,500) is one of the beautiful progressive towns in the Niagara Peninsula. Apply to A. M. Casselman, Dunnville, Ont.

Registered Nurses (4) for Staff Duty. 8-hour day; 44-hour week; $5\frac{1}{2}$ day week. Gross salary: \$136.50 per month. For further information apply to Miss E. W. Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ont.

Graduate Nurses for General Duty in 350-bed Tuberculosis Hospital. Salary: \$100 per month with full maintenance. 6-day week. Good living conditions. State in first letter age, date of graduation, experience if any, and date available for duty. For further information apply to Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Registered Nurses for General Staff at Tranquille Sanatorium, which is situated on Kamloops Lake, near Kamloops, B.C. Gross salary for 8-hour day, 6-day week: \$146.11 per month during 1st year; \$156.11 per month during 2nd year; and a \$5.00 per month raise in 3rd, 4th, and 5th years of service, minus \$27.50 monthly for board, room and laundry. 31 days vacation per annum with pay, plus 11 days statutory holidays. 14 days sick leave each year, accumulative, with pay, plus 6 days incidental illness. Superannuation plan. Up to \$50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

Licensed Nurses for General Duty in 51-bed hospital. Nurse with Operating-Room experience. Basic salary: \$114.50 per month plus full maintenance; \$5.00 increase in salary after 6 months. 3 weeks' vacation each year with pay. Apply to Miss M. N. DeVere, Supt. of Nurses, Saguenay General Hospital, Arvida, P.Q.

Registered Nurses for General Duty at Royal Jubilee Hospital, Victoria, B.C. State in first letter year of graduation, experience, references, etc., and when available. Starting salary: \$140 per month, living out. Yearly salary increases up to \$150 in 4 years. Special post-graduate training—Starting salary: \$150 with increases to \$170 in 4 years. Laundry allowed. A few rooms available in residence. Sick leave allowance, cumulative 1½ days per month. Superannuation. 4 weeks vacation per year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nursing.

Graduate Nurses for Operating-Room, Charge Duty, and General Duty. X-Ray Technician. Apply giving experience, to Supt., Blanchard-Fraser Memorial Hospital, Kentville, N.S.

Graduate Nurse, with Public Health certificate, for Nursing Service in Secondary Schools, Apply, stating qualifications, experience, age, and other particulars, to Miss Mollie Towers. Sec., Board of Education, Sault Ste. Marie, Ont.

Public Health Nurses for generalized service with Peel County Health Unit. Salary: \$1,800-\$2,100 according to experience. Car supplied or car allowance \$500-\$600 per year. Unit will assist in purchase of car. Apply to Dr. D. G. H. MacDonald, Director, Court House, Brampton, Ont.

Operating-Room Nurse. Salary: \$110. Full maintenance, laundry, Blue Cross Hospitalization. \$60 yearly increase up to 3 years. General Floor Duty Nurse. Salary: \$100. Same benefits. Apply, with references, to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Registered Nurse for special assignment in hospital. Opportunity for advancement. Preference given to one with post-graduate work in Tuberculosis Nursing and possessing administrative ability. Apply to Supt. of Nurses. Muskoka Hospital, Gravenhurst, Ont.

Registered Nurses for 65-bed hospital. Salary: \$140 per month with full maintenance or \$150 without room. 8-hour day and 6 day week. 30 days' holiday with pay after 1 year of service. Apply to Notre Dame Hospital, North Battleford, Sask.

WANTED

for

ROSEWAY HOSPITAL, SHELBURNE, NOVA SCOTIA

General Duty Nurses for 160-bed hospital (40 beds general hospital plus 120 beds tuberculosis hospital). Salary: \$1,140 per annum plus full maintenance. Pleasant living and working conditions. 6-day week; 3 weeks' holiday with full pay after a year's service.

Apply to:

N.S. CIVIL SERVICE COMMISSION, P.O. BOX 943, HALIFAX, N.S.

Official Directory

CANADIAN NURSES' ASSOCIATION

1411 Crescent St., Montreal 25, P.Q.

President Miss Rae Chittick, Faculty of Education, University of Alberta, Calgary, Alta Past President Miss Fanny Munroe, Royal Victoria Hospital, Montreal 2, P.Q. First Vice-President Miss Ethel Cryderman, V.O.N., 281 Sherbourne St., Toronto 2, Ont. Second Vice-President Miss Evelyn Mallory, University of British Columbia, Vancouver, B.C. Third Vice-President Miss Marion Myers, Saint John General Hospital, Saint John, N.B. Honorary Secretary Rev. Sister Denise Lefebvre, 1185 St. Mathew St., Montreal 25, P.Q. Honorary Treasurer Miss Lillian Pettigrew, Winnipeg General Hospital, Winnipeg, Man.

COUNCILLORS AND OTHER MEMBERS OF EXECUTIVE COMMITTEE

Numerals indicate office held: (1) President, Provincial Nurses Association; (2) Chairman, Committee on Institutional Nursing; (3) Chairman, Committee on Public Health Nursing; (4) Chairman, Committee on Private Duty Nursing,

Alberta: (1) Miss B. Emerson, 23 Rene LeMarchand Mansions, Edmonton; (2) Miss A. Anderson, Royal Alexandra Hospital, Edmonton; (3) Miss G. Hutchings, Strathmore; (4) Miss Orma Smith, Galt Hospital, Lethbridge.

British Columbia: (1) Miss E. Mallory, University of B.C., Vancouver; (2) Miss E. Davis, Ste. 22. 1311 Beach Ave., Vancouver; (3) Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; (4) Miss E. Otterbine, Ste. 5 1334 Nicola St., Vancouver.

Manitoba: (1) Miss I. Barton, Veterans' Home, Winnipeg; (2) Miss V. Williams. St. Boniface Hospital. (3) Miss D. Dick, City Health Dept., Winnipeg; (4) Miss M. Muir, 16 Gordon Apts., Winnipeg.

New Brunswick: (1) Miss M. Myers, Saint John General Hospital; (2) Sr. M. Rosarie, St. Joseph's Hospital, Saint John; (3) Miss Lois Smith, Walker Apts., York St., Fredericton; (4) Mrs. B. Nash Smith, 57 Queen St., Moncton,

Nova Scotia: (1) Miss L. Grady, Halifax Infirmary; (2) Sr. M. Beatrice, Glace Bay; (3) Miss M. Shore. V.O.N., Halifax; (4) Miss M. Stevens, Box 345, Amherst.

Ontario: (1) Miss N. D. Fidler, School of Nursing, University of Toronto, Toronto 5; (2) Miss C. Tavener, 42 Isabella St., Toronto 5; (3) Miss S. Wallace, Dept. of Health, Parliament Bldgs., Toronto 2; (4) Miss D. Marcellus, 166 Roxborough St. E., Toronto 5.

Prince Edward Island: (1) Miss D. Cox, 101 Weymouth St., Charlottetown; (2) Sr. Mary Irene, Charlottetown Hospital; (3) Miss E. Wheler, Summerside; (4) Miss M. Thompson, 20 Euston St., Charlottetown.

Quebec: (1) Rev. Soeur Valérie de la Sagesse, I.E., Hôpital Ste-Justine, Montreal 10; (2) Miss C. Lynch. Allan Memorial Institute, 1025 Pine Ave. W., Montreal 2; (3) Miss H. Perry, 4814 Fulton Ave., Montreal 26; (4) Mlle A. M. Robert, 3622 rue St-Denis, Montréal 18.

Saskatchewan: (1) Mrs. D. Harrison, Experimental Station, Swift Current; (2) Miss S. Leeper, 130-8th St. E., Saskatoon; (3) Miss G. McDonald, No. 5, 2025 Lorne St., Regina; (4) Mrs. E. Lewis, 205 Bliss Block, Prince Albert.

Religious Sisters: Rev. Sr. Columkille, St. Paul's Hospital, Vancouver, B.C.; Rev. Sr. M. Kathleen, St. Michael's Hospital, Toronto 2, Ont.; Rev. Sr. St. Gertrude, Civic Hospital, 1051 Chemin de la Canardière, Quebec, P.Q.; Rev. Sr. M. Irene, Holy Family School of Nursing, 15th St. W., Prince Albert, Sask.

CHAIRMEN OF NATIONAL COMMITTEES

Committee on Constitution and By-Laws: Miss Eileen Flanagan, 3801 University St., Montreal 2, P.Q Committee on Educational Policy: Miss Agnes Macleod, Dept. of Veterans Affairs, Ottawa, Ont. Committee on Institutional Nursing: Rev. Sister Delia Clermont, St. Boniface Hospital, Man. Committee on Labor Relations: Miss E. K. Connor, Central Alberta Sanatorium, Calgary, Alta. Committee on Private Duty Nursing: Miss Barbara Key. 123 Bold St., Apt 56, Hamilton, Ont. Committee on Public Health Nursing: Miss Helen McArthur, Canadian Red Cross Society, 95 Wellesley St.. Toronto 5, Ont.

EXECUTIVE OFFICERS

International Council of Nurses: 1819 Broadway, New York City 23, U.S.A. Executive Secretary, Miss Anna Schwarzenberg.
Canadian Nurses' Association: 1411 Crescent St., Montreal 25, P.Q. Genera Secretary, Miss Gertrude M. Hall. Assistant Secretary, Miss Winnifred Cooke.

PROVINCIAL EXECUTIVE OFFICERS

Alberta Ass'n of Registered Nurses: Miss E. Bell Rogers, St. Stephen's College, Edmonton.
Registered Nurses' Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.
Manitoba Ass'n of Registered Nurses: Miss Lillian Pettigrew, 214 Balmoral St., Winnipeg.
New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.
Registered Nurses' Ass'n of Nova Scotia: Miss Nancy Watson, 301 Barrington St., Halifax.
Registered Nurses Ass'n of Ontario: Miss Matida E. Fitzgerald, Rm. 715. 86 Bloor St. W., Toronto 5.
Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlotte-

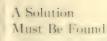
Association of Nurses of the Province of Quebec: Miss E. Frances Upton, 506 Medical Arts Bldg., Montreal 25. Saskatchewan Registered Nurses' Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall. University of Saskatchewan. Saskatoon.

VOLUME 43 NUMBER 9 MONTREAL SEPTEMBER 1947

CANADIAN NURSE



Reports and Papers of the I.C.N. Congress



Dr. H. Agnew



Officers of the I.C.N. 1947

Photo by Harri & Eains, Washington, D (





When you say "USEFUL" hands, LISP!

KEEPING useful hands youthful is a problem, and nowhere is this truer than in the nursing profession. Passive, useless hands require a minimum of care. Active hands need active measures.

Counteract the innumerable washings necessary in any hospital and keep your hands soft, white and attractive by using 'Wellcome' BRAND Toilet Lanoline daily. Massaged gently into the hands every night and,

used more sparingly, in the morning after washing, this soft, soothing cream will supplement the natural oils of the skin and give "on duty" hands that "off duty" look.

Tubes of two sizes at all reliable pharmacies.

'WELLCOME'

Toilet Lanoline



BURROUGHS WELLCOME & CO.

(The Wellcome Foundation Ltd.)
MONTREAL

For a generous free sample simply mail this card to P.O. Box 159, Montreal. Please send me a free sample of Wellcome BRAND Toilel Lanoline.

Name

Address

HRINA FOODS SPRCIAL DIRTS

When a restricted dietary regimen is prescribed, better co-operation from the patient is obtained if preparation of the diet is made as simple and convenient as possible and variety is provided.

Heinz Strained Foods may be safely recommended because they are thoroughly cooked uniform fine particles with the coarse indigestible fibre removed. Being smooth, they cause a minimum of mechanical irritation to sensitive digestive systems. Not only are they easily digestible, but in general their nutritional value is very good. The wide assortment of Heinz Strained Foods available provide your patients with more variety and aid in giving nutritional balance to restricted diets.

It is beyond the scope of the H. J. Heinz Company to include specific diets for special and pathological conditions in any literature. But the Heinz Nutritional Charts are prepared especially for the guidance of physicians, dentists, nutritionists, dietitians, and public health workers, and have proved useful in devising and prescribing diets for children, the sick and convalescent, under and over-weight persons and normal individuals needing a well-balanced diet. These charts are available for professional use by writing to H. J. Heinz Company of Canada Ltd., 420 Dupont Street, Toronto 4, Ontario.

HEINZ STRAINED FOODS

Uses

- (1) Soft Diets for Special and Pathological Cases
- (A) INABILITY TO MASTICATE OR SWALLOW
 - 1. Sore Mouths or Throats
 - (1) Tooth Extractions
 - (2) Broken Jaws
 - (3) Tonsillectomies (4) Infections
 - (2) Trench Mouth
 - (Vincent's Angina)
 - (b) Severe Septic
 - Sore Throat
 - (c) Abscesses
 - (d) Quinsy
- 2. Paralysis
- 3. Senility
 4. Extreme Mental Deficiency
- 5. Obstruction of Esophagus
 - (1) Tumor

in tube feedings.)

(2) Stricture (Lye Burns) (Strained foods may be incorporated

(B) GASTRO-INTESTINAL CONDITIONS

- 1. Gastric Ulcer
- 2. Gastric Cancer
- 3. Gastritis
- 4. Intestinal Ulcer
- 5. Enteritis (Colitis)
- 6. Cholecystitis
- Diverticulosis
- 8. Constipation
 - (1) Spastic
 - (2) Mild Atonic
 - (a) Infants
- (b) Convalescents 9. Vomiting in Pregnancy
- 10. Cyclic Vomiting
- 11. Amebic Infections
- (C) CASES WHERE BURDEN ON DIGES-TIVE SYSTEM SHOULD BE LIGHT
 - 1. Convalescence
 - (1) Febrile Conditions
 - (a) Scarlet Fever
 - (b) Measles
 - (c) Diphtheria
 - (d) Typhoid
 - (e) Undulant Fever
- (2) Operations 2. Exhaustion
- 3. Old Age
- 4. Diseases of Heart
- Nervous Indigestion
- (2) Convenience in Supplying Essential Nutrients where a soft diet is not demanded
- A. Invalids B. Convalescents
- E. Diabetes F. Nephritis
- The Aged
- G. Epilepsy
- D. Pernicious Anemia
- H. Pregnancy

anadian

Authorized as second-class mail, Post Office Department. Ottawa Editor and Business Manager: MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

CONTENTS FOR SEPTEMBER, 1947

THE I.C.N. CONGRESS 1947	673
Professional Organizations and Nurses' Working Conditions	682
International Education of Nurses	686
POST-GRADUATE EDUCATION	690
NURSING GROUPS OTHER THAN REGISTERED NURSES	693
A SOLUTION MUST BE FOUND	696
RAPPORT DU CONGRÈS D'ATLANTIC CITY 1947	699
GROUP STUDY AT THE VETERANS' VILLAGE	703
Leisure Years — Pleasure Years	706
Notes from National Office	709
WITH UNRRA IN GERMANY L. M. Creelman	710
A STUDENT REPORTS ON THE I.C.N. CONGRESS	713
Book Reviews	721
News Notes	730
OFFICIAL DIRECTORY	735

SUBSCRIPTION PRICE

Until September 30, 1947, new subscriptions and renewals will be accepted at the old rates which have been in effect for over twenty years, namely: \$2 per year; three years for \$5; student nurses, \$2 for eighteen months; foreign, including U.S.A., \$2.50 per year.

On and after October 1, 1947, new rates will be in effect on all classes of subscriptions, as follows: Graduate nurses —\$3 per year; two years for \$5. Student nurses—\$2 per year; three years for \$5. Foreign, including U.S.A., \$3.50 per year. In combination with *The American Journal of Nursing*, \$7 per year to Canadian subscribers.

Four weeks' advance notice, and the old address as well as the new, are necessary

for change of subscriber's address.



AYERST, McKENNA & HARRISON LIMITED . Biological and Pharmaceutical Chemists . MONTREAL, CANADA

Reader's Guide

Time, opportunity and, inevitably, expense permitted only a small fraction of the nurses of Canada to attend the congress sessions of the International Council of Nurses in Atlantic City last May. To compensate in a measure, we have concentrated in this issue on bringing you a portion at least of the papers which were presented. To provide the atmosphere and to add local color to these manuscripts. Gertrude M. Hall, the energetic general secretary-treasurer of the C.N.A., has highlighted the major events and business of this momentous occasion. She passes on to each of you the spark of enthusiasm for the bigger and better things for nursing everywhere which united action through the I.C.N. can provide.

Though there have been references to the I.C.N. from time to time in the *Journal*, many of the pertinent data are not familiar to us all. The September issue of the *American Journal* of *Nursing* carries an outline of background information about the I.C.N.

With more than a dozen papers to choose from, it was difficult to decide which should be reprinted in this issue. Space limitations precluded the practicability of reproducing all of them. Each capable speaker had explicit messages for the nurses of all lands. Folios of the Congress Papers and Proceedings of the Congress are available from I.C.N. Headquarters, 1819 Broadway, New York 23, N.Y. Subscriptions to *The International Bulletin* may also be sent to that address.

The selection of papers printed in this issue include those prepared by the Canadian contributors to the program-Ethel Johns and Mary S. Mathewson. Gerda Höjer, who presented the very enlightening account of the functions of the professional organization in taking care of nurses' working conditions, was installed as the new president of the I.C.N. Miss Höjer is presently president of the Swedish Nurses' Association. C. A. Nothard presents the pattern that has been developed in South Africa to deal with the ubiquitous problem of those persons other than registered nurses who are caring for the sick. Shortage of nurses is even more acute in the European countries than it is in Canada.

Our cover picture portrays the officers of the I.C.N. for the next biennium. Left to right, front row: treasurer, G. E. Davies, England; president, Gerda Höjer, Sweden; second row: third vice-president, Grace M. Fairley, Canada; second vice-president, Katharine J. Densford, U.S.A.; first vice-president, Mary I. Lambie, New Zealand.

We are indebted to **Dr. Harvey Agnew**, secretary of the Canadian Hospital Council and editor of *The Canadian Hospital*, for the privilege of reprinting his analytical editorial from the August, 1947, issue. Every nurse should read it.

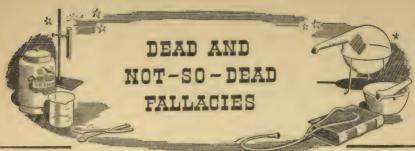
Under the able guidance of Isobel Black, the public health nursing students of the University of Manitoba School of Nursing organized study groups with the young parents in the veterans' village near the campus. It proved an eminently successful experiment, so much so that it is well worth the careful study of other university schools. You will find Miss Black's report on the Public Health Nursing page.

After many years of active leadership in nursing, **K. Ethel Gray**, of Victoria, decided to enter the business world as a purveyor of security in the form of life assurance policies. Here she gives us a picture of why the individual nurse so often has to use her own initiative in the matter of pensions or annuities, and indicates the various avenues that are open to nurses.

This month you have your last opportunity, for a time at least, to subscribe to The Canadian Nurse at the old subscription rate. We don't know of anything else that you can buy today at the same price you paid for it in 1925, do you? Of course the increase is only one dollar per year, which still makes your Journal a very reasonably priced magazine. However, if you are really spry and mail your money before midnight, September 30, 1947, the Journal will come to you for as long as you pay for at the old rates. Consult the box on the Table of Contents page. Circulation figures by provinces, as at August, were as follows.

Alberta, 820; British Columbia, 1,226; Manitoba, 556; New Brunswick, 616; Nova Scotia, 577; Ontario, 3,424; Prince Edward Island, 146; Quebec, 1,044; Saskatchewan, 650







To treat spider bites caused by venomous tarantulas in 15th Century Italy, lively music was played.

The vigorous rhythm supposedly healed the victims — hence the Tarantella!



Some folks today believe it is unsafe to leave food in opened cans.

This is not true. The U.S. Department of Agriculture says: Food is just as safe left in opened cans—just keep it cool and covered.



A M E R I C A N C A N C O M P A N Y MONTREAL HAMILTON TORONTO VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

—a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

CANNED FOOD IS GRAND FOOD

AMERICAN CAN COMPANY
Medical Arts Building, Hamilton, Ont.
Please send me the new Canadian edition of "THE CANNED FOOD
REFERENCE MANUAL," which is free.
Name
Professional Title

Address

City.....Province..

062



BONE FLOUR, nature's own calcium and phosphorus is assimilable. Clinical tests show that pregnant mothers given bone meal have little or no dental caries, leg cramps... and the babies "whose mothers had been given bone meal had such long, silky hair and such long nails that the phenomenon was remarked

on by the nurses." From "Report on the Clinical Use of Bone Meal" by E. M. Martin, M.D., in the Canadian Medical Association Journal, Vol. 50.

The whole story of OSTEO-TABS cannot be told in this advertisement. Write today for Trial Package and Brochure... "Report on the Clinical Use of Bone Meal".











s it prevents peptic digestion by immediately precipitating pepsin

 it is an amphoteric, unabsorbable substance and will not disturb the acidbase balance of the body

Bottles of 12 fl. oz.

Amphojel · Alumina Gel · Wyeth

Trade Mark Reg. in Canada

JOHN WYETH & BROTHER (CANADA) LIMITED • WALKERVILLE, ONTARIO



... the renewable fabric finish that resists dirt ... soil and ... moisture!

Uniforms stay crisper, cleaner-looking longer . . . wash more easily . . . when they are protected with Johnson's DRAX! And both these advantages mean a cutting down of laundering costs!

DRAX... made by the makers of Johnson's Wax... is an amazing new, *invisible* fabric finish that gives each thread of the fabric the wonderful protection of wax. Dirt slides off, water and liquids wipe easily away... because dirt is not ground into the fabric it washes easier, cleaner without fabric-fatiguing rubbing and scrubbing.

DRAX is grand for curtains, tablecloths, place mats and other washable things, too. It saves so much time in the washing . . . so much wear . . . and keeps things looking cleaner longer, it's well worth looking into. Find out about DRAX today!

DRAX-

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

SEPTEMBER, 1947

for the beginning of clinical instruction



These four texts have supplied a vital place in many schools of nursing . . . which is proved by the fact that the "youngest" is in its 4th edition, while of the others, two are in their 7th edition and one in its 15th edition. Certainly an outstanding record!

FMERSON & TAYLOR

ESSENTIALS OF MEDICINE

200 ILLUSTRATIONS

This 15th edition, completely revised and reset, stresses more than ever the patient as a person. Every phase of medicine has been covered to include all the latest advances and their relation to medical nursing care as applied to prevention and treatment of disease. Here is a text to stimulate interest in medical nursing and make better students

> 4 COLOR PLATES \$3.75

ELIASON, FERGUSON, FARRAND

SURGICAL NURSING

688 PAGES

259 ILLUSTRATIONS 585 PAGES

Designed to provide the student with a background in the field of surgery and to detail the principles and technics that concern the nurse in surgical relationships. Tells the student nurse the what, how and why of each nursing procedure in the field of surgical nursing.

7 IN COLOR

7th Edition

\$3.75

ZABRISKIE & EASTMAN NURSES HANDBOOK OF OBSTETRICS

714 PAGES

A complete guide to obstetric nursing . . . complete because a nurse and an obstetrician have contributed to it from their wide experience. Entire management and nursing care is given for antepartum, parturition, postpartur and neonatal care. Widely used—and widely praised.

The text of this new 4th edition has been entirely rewritten.

reorganized into units and reset in the widely accepted double column format. The earlier editions were received with enthusiasm, and this edition, since its release, has shown that it will continue in a leading position.

7th Edition

376 ILLUSTRATIONS

\$3.75

JEANS, RAND, BLAKE

ESSENTIALS OF PEDIATRICS

628 PAGES

86 ILLUSTRATIONS

9 IN COLOR

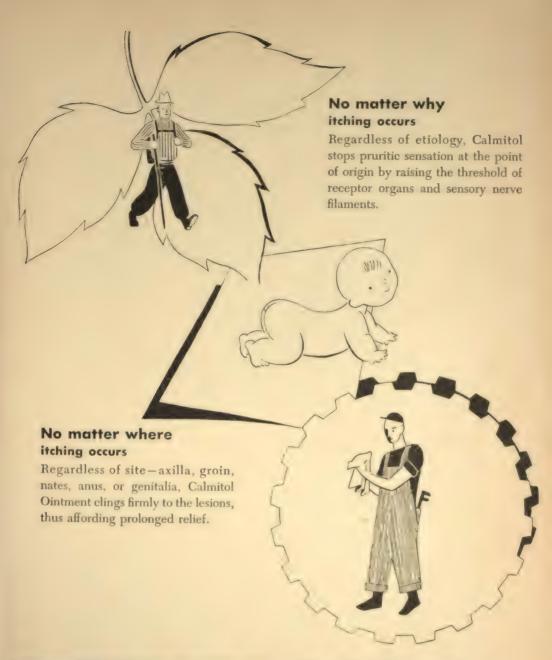
\$3.75

J. B. LIPPINCOTT COMPANY

2083 Guy Street

Montreal, 25, P.Q.





CALMITOL

The Learning Miles Go. Lid.
I NOTRE DAME ST. W., MONTREAL I, CANADA

No matter how much or how often

Regardless of extent or frequency of use, Calmitol is safe. It does not contain harmful phenol or cocaine. Its active antipruritic in gredients, camphorated chloral and hyoscyamine oleate, will not be absorbed systemically.

They look to you, Doctor..

"It has to be considered whether the damage to tissues, whether gross or only microscopic, will outweigh the advantage possibly gained by killing bacteria; some antiseptics are caustic or irritant, others comparatively bland." Garrod, L.P., and Keynes, Geoffrey, L. (1937) Brit. Med. J., 2, 1233

You, in choosing an antiseptic for the prevention, or chemotherapeutic for the treatment, of an infection, have knowledge and experience to guide you. But what of the unskilled person using an antiseptic at home! What does he know of this important consideration! Nothing, or next to nothing at all.

YET HERE is the crucial problem of all antisepsis; most acute, obviously, with antiseptics which are toxic at all bactericidal strengths; progressively less acute as the margin widens between the bactericidal dilution and the dilution at which toxic effects first appear.

consider Now an antiseptic with which the problem hardly arises at all. One which, though bactericidal in considerable dilution, is bland at any strength. One which may be applied direct to the tissues without risk of either injury or interference with natural healing processes. Such a nonpoisonous antiseptic is 'Dettol.'

MOREOVER, and most importantly, 'Dettol' has low selectivity. It is rapidly lethal

to a diversity of pathogenic organisms, including Strep.pyogenes, Staph.aureus, B.coli, B.typhosum, and such wound contaminants as B.proteus and Ps.pyocyanea. And it remains active under clinical conditions, i.e., in the presence of blood, pus and tissue debris.

ADD TO THESE remarkable properties that 'Dettol' is pleasant to smell and agreeable to use, and that it does not stain either linen or the skin, and it will be seen that here is an almost ideal antiseptic for general use in Canadian homes, as it already is in millions of homes in other parts of the Empire.

'DETTOL' OBSTETRIC CREAM is a preparation of 30 per cent. 'Dettol' in a suitable vehicle, the right concentration for immediate use in obstetrics. Applied to the patient's skin and to the gloves of the operator, it forms for more than two hours a dependable barrier against re-infection by haemolytic streptococci.

RECRITT & COLMAN (CANADA) LIMITED, PHARMACGUTICAL DIVINION, MONTREAL MIS

670 Vol. 43, No. 9



"I'm glad you asked me what to do about your 'student nurse skin troubles', Jane, because we R. N.'s certainly know the answer -- NOXZEMA.

"During my first year in training Noxzema was a lifesaver for my sore, chapped hands. Because it has a medicated formula, it not only helps soothe and soften the red roughness, but actually helps heal the tiny cuts and cracks your hands get from strong hospital solutions.

"Then, too, after standing on my feet all day, I learned there's nothing like a cooling Noxzema massage to rub the fire out of my aching feet and legs.

"Best of all, I found Noxzema a wonderful complexion cream that I can use 24 hours a day. It's a greaseless night cream -- and a soothing daytime powder base. It keeps my complexion smooth and soft -- helps clear up unattractive blemishes and irritations, too.

"Try Noxzema, Jane. I'll bet you my diploma you'll find the answer to your problems in the little blue jar!"

SEPTEMBER, 1947 671



You BUILT it, Doctor...We hope You'll USE it!

Your patronage made this plant possible. Without your cooperation in prescribing and using Abbott products, we could not have taken our present forward step. Your loyalty to us gave us the courage. From this new, up-to-the-minute plant, pharmaceuticals are already speeding to every part of the Dominion. We hope, Doctor, that you will make increasing use of our enlarged and improved facilities.

ABBOTT'S NEW MONTREAL PLANT

This new, spacious structure, conveniently located in Montreal, is something more than a building. It is a testimonial to your faith in Abbott, to your preference for Abbott products through the years.

Here is one of the truly fine pharmaceutical laboratories of the American continent. In this new plant we shall continue an old resolve: to give to medical men and to their patients, the best service within our power.

ABBOTT LABORATORIES LIMITED . MONTREAL



"Changing Ideas - Changeless Ideals"

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER NINE

MONTREAL, SEPTEMBER, 1947

The I.C.N. Congress 1947

It may be truly said that Canada's five official delegates to the International Council of Nurses Congress spent two weeks, at least, where an atmosphere of "One World" prevailed.

BOARD OF DIRECTORS

Beginning with the meetings of the Board of Directors on May 5-6, at which the president and general secretary of the C.N.A. were present, a three-day session of the Grand Council of the International Council of Nurses was held May 7-9. The latter is the voting body of the organization which is a federation of national nursing organizations. Member organizations are entitled to four representatives, in addition to the president, who serves as a member of the Board of Directors. The Grand Council last met in London in 1937.

When the Board of Directors met in London in September, 1946, it was agreed that the world upheaval had created not only very serious problems but also important opportunities for nurses. It was agreed that there was urgent need for clarification of issues and for a strengthened organization to assist nurses of all nations in their adjustments to the rapid changes of the postwar period.

Upon renewal of the invitation extended in 1941 by the American Nurses' Association, plans were made for the meeting of the Grand Council and for a Congress in the United States in 1947. Great tribute must here be paid to the co-operative planning between the officers and administrators of the International Council of Nurses and the American Nurses' Association, and to the membership of the American Nurses' Association who contributed so much financially as well as in personal service. As a result of these heroic efforts, representatives from thirty-one countries were enabled to attend the Grand Council meeting in Washington.

Spring in all its glory had just come to Washington. The shrubs and flowers were a blaze of color and beauty; the blue skies and sunshine.

SEPTEMBER, 1947 673

coupled with warm breezes, dispelled all trace of the memories of the cold, bleak days which, until so recently, had stalked the paths of many of our overseas members. The warmth and charm of our hostess organization members, under the capable leadership of Ashby Taylor, president of the Graduate Nurses' Association of the District of Columbia, permeated and remained throughout our entire stay in Washington.

Nurses from thirty-two nations gathered on the grassy slopes of the Palisades Field House to study such American institutions as hot dogs, barbecues, popcorn, and eskimo pies. The picnic, a relaxation highlight of the five-day conferences, was sponsored by the local nurses. Language may have been a conversational hazard, what with countries as farflung as China, Greece, India, and Finland represented, but American food served as the happy common denominator. Everyone present entered wholeheartedly into the spirit of the evening and participated in variety program, consisting of folksongs, dances, and stunts of every The Canadians were firmly resolved to acquire one, at least, truly national form of entertainment before the next meeting of this nature.

THE GRAND COUNCIL

A banquet for the officers and Grand Council of the International Council of Nurses was held by the nurses of the District of Columbia on Tuesday, May 6. Among the 800 guests at the dinner, held in the Presidential ballroom of the Statler Hotel, were women prominent in United States Government circles and representatives of leading health organizations. Dean Elmer Louis Kayser (dean of university students and professor of history at George Washington University) was the principal speaker. Dean Kayser concluded his address on "The World Today" by saying:

I confess only to be interested in a better world, interested enough so that I am willing to have my country shoulder her obligation in it. I want a world where organizations like yours can carry on their great work without being cabined, cribbed, confined by the selfish power of a few individuals, tyrannically dominating a totalitarian society. I want a society in which the individual, in which you nurses, can find a livelihood and at the same time a full life. I want my country to continue free, in a free world where not only the dead will not have died in vain but where the living will not live in despair.

Mrs. Harry S. Truman, wife of the President of the United States and patroness of the 1947 International Council of Nurses Congress, received officers and Grand Council members at tea in the White House on Tuesday,

May 6.

Throughout the entire week, local nurses were hostesses at supper parties, when groups of six to eight nurses from various countries were entertained in the homes of the hostesses, thus enabling the visitors to obtain at least a glimpse of American home life. These proved to be very happy, socializing events and were commented upon as one of the delightful

experiences of the week.

Lest the reader may conclude that this was a week of festivity and gaiety only, let me hasten to add that the social events were interspersed with long and arduous business sessions. For example, the Grand Council accepted the challenge to strengthen the International Council of Nurses for its expanding role in International Health and Education when it empowered the new Board of Directors to take all necessary steps to put the report of the Study Committee into effect and to set up a special committee on Ways and Means.

Action followed presentation of a detailed analysis and report by Mrs. Alma H. Scott (U.S.A.), chairman of the Study Committee and director of the study of the structure, functions, and reorganization of the International Council of Nurses. London will again be the site of headquarters as soon as facilities are available, it was

voted.

During the three-day Grand Council meetings, Miss Taylor summarized briefly the developments of the tenyear period since the last Congress.

She stressed the fact that headquarters, as now organized, is wholly inadequate to carry the type of program necessary if the International Council of Nurses is to take its place as the acknowledged leader of nursing throughout the world. For the necessary expansion, ways and means of increasing the income of the Council must be found. An increase in the dues paid by member nations was the obvious first step, and many speakers upheld the view that nurses themselves should finance the administration of this organization. Some felt that there could be no objection to securing funds from other sources, such as Foundations for special projects.

The Membership Committee brought out three current problems created by postwar readjustments. In some European countries, the forced relationship of national associations to trade unions is significant. The International Council of Nurses is essentially a professional, nonpolitical body, open to all races and creeds, and any deviation from this is contrary to its aims. Further, the Council has always presumed that the national associations would be comprised solely of graduates having had not less than a three-year basic course. It now finds that at least one national association admits persons trained only in mental nursing. In other countries, the national nursing associations have been dissolved by political authority, as in Austria, Germany, and Japan. This leaves no national association to link with the International Council of Nurses, which is a great loss to the profession, nationally and internationally.

A Constitution and By Laws of a national association, to guide member and potential member countries, was presented. The clause on membership, as amended, stated that "All members of this association should be graduate, professional nurses, graduates of an accredited, state-recognized school of nursing, which meets the requirements of a nursing school as determined by the International Council of Nurses, this requirement

to be contingent upon the adoption of such minimum requirements by the International Council." The Council accepted a recommendation that acceptance of countries applying for active membership should be delayed until the Grand Council is reorganized and a representative can study the nursing situation in the countries applying. Meanwhile, the Council proposed to allow countries to send associate members to meetings until they can be accepted as full members.

The adoption of minimum standards for admission to the International Council of Nurses has still to be carried out and could not be settled at these meetings, as it was not on the agenda. The establishment of minimum standards of qualification for the members of national organizations affiliated to the International Council of Nurses would give the nurses of various nations support in resisting internal political and other outside pressure to lower standards of training below those which are acceptable to nurses themselves.

The Education Committee is revising its pamphlet "Educational Program of the School of Nursing"



A. Goodrich, U.S.; E. Taylor, U.S.; M. Mila, Spain; K. Pohjala, Finland; Dame E. Musson, G.B.; B. Helgestad, Norway; G. Fairley, Canada; A. Schwarzenberg, I.C.N.; D. Bridges, G.B.

and will change the name to "The Basic Education of the Professional Nurse." A second pamphlet on "The Post-Graduate Education of the Professional Nurse" is being prepared.

Suggested next steps, as outlined by the Study Committee, were ac-

cepted:

- 1. Selection of address for permanent headquarters.
- 2. Appointment of standing and special committees, including a temporary special committee on Ways and Means.
- 3. Meeting of Finance Committee and preparation of budget.
- 4. Conference of Committee on Finance with the headquarters committee to discuss the headquarters budget.
- Presentation of budget to new Board of Directors of the I.C.N. for consideration and approval.
- 6. Conference of Committee on Finance and temporary special committee on Ways and Means to discuss approved budgetary items and to select those which might be of interest to particular foundations, to other philanthropic agencies and individuals.
- 7. Preparation of materials for presentation to these foundations, agencies and individuals in relation to contribution of funds to finance the particular project or projects to which the appropriate budgetary item or items refer, in order to supplement dues.
- 8. Appointment of basic staff at I.C.N. headquarters.
- Establishment of Bureau of Education, and selection and appointment of educational secretary.
- 10. Publication and interpretation of functional chart of the I.C.N. for the purpose of informing member associations about the program of activities to be sponsored by the I.C.N. in the immediate future.
- 11. Implementation of resolutions concerning relations with Florence Nightingale International Foundation, United Nations Educational Scientific and Cultural Organization, and World Health Organization.
- Selection and appointment of editorresponsible for publications and public relations program.
- 13. Development of library facilities and appointment of librarian.
- 14. Appointment of statistical and research worker.

Proposed changes in the Constitution and By-Laws, presented by Mrs. Scott as chairman of the Committee on Revision of Constitution and By-Laws, were accepted as designed to enable the I.C.N. to function more efficiently under a variety of world conditions.

A motion of ""deep and sincere thanks to Mrs. Scott and her committee" was voted by the Grand Council, with special mention of "the colossal work given by Mrs. Scott without charge to the I.C.N. over several months of continuous service."

The Study Committee report was illustrated by a large chart showing the proposed plan of organization for the future. This is to be published and interpreted for the information of all I.C.N. member associations.

THE CONGRESS

The first gathering of the nurses of all nations attending the Ninth Congress of the International Council of Nurses was for the Memorial Service in honor of the late Mrs. Bedford Fenwick, the founder. The service was held on Sunday, May 11, at 5.00 p.m. and hundreds of nurses were present in the beautiful hall of the Auditorium in Atlantic City. Organ music rose to the rafters as the great company assembled, and the special music of the service was led by the Chapel Choir of the Westminster Choir College, whose red cassocks against the dull purple hangings added to the colorful setting.

Miss Effie J. Taylor gave the memorial address, reminding those assembled of Mrs. Bedford Fenwick's inspiring presence at the last International Congress in London in 1937, when she was already eighty years of Miss Taylor read the citation which was to have been presented to Mrs. Fenwick from her nursing colleagues throughout the world grateful recognition of her unique and lifelong contribution to the nursing profession, of her clarity of vision, her original and fearless quality of mind, and her unshakeable determination that the nursing profession must be free to determine its own destiny, to which end she had founded

and defended the International Council of Nurses.

On Monday morning, May 12, the president, Miss Effie Taylor, declared the Congress to be in session. Dr. Joseph R. Narcot gave the invocation. A letter conveying greetings from President Truman was read. Miss Taylor then pointed out the significance of the date for the opening of this Congress, it being the 127th anniversary of the birth of Florence Nightingale. Among the delegates, said Miss Taylor, were members of forty countries, and she was happy to welcome them, especially as many had overcome almost insurmountable difficulties in order to attend. She welcomed also the many distinguished guests-members of the government, of the learned professions, and of world organizations and institutions, who were so interested in nursing that they made time to honor the convention with their presence.

Dr. Thomas Parran, Surgeon General, United States Public Health Service, described the nursing profession as "the spearhead of the fight for life." In spite of appalling conditions, there was no shortage of hope. The world health organization was taking shape, with great possibilities for the future. There was an opportunity to discard outworn ideas, and the nurses could chart a course to give strength and vision to national health. Nurses must be assured of public recognition and of economic security.

Dr. Edward L. Bortz, presidentelect of the American Medical Association, in bringing greetings from their 131,000 members, felt that the conference was of importance and significance to the whole world. The medical profession was hampered when nursing was inadequate, and he urged that nursing beware of too much specialization, as the doctors are now faced with this problem. The Medical Association, he said, is hoping to have a liaison with nursing leaders.

Dr. Brock Chisholm, the executive secretary of the World Health Organization, suggested that the International Congress should consider the important role which nursing should play in world health, that it should pass its recommendations on to the Interim Commission of the World Health Organization and that this organization would expect, and would look forward to, active cooperation with the nursing profession.

In thanking the speakers, Miss Daisy Bridges, president of the National Council of Nurses of Great Britain and Northern Ireland, said:

The friendship of our countries in the war years has deepened in the days of peace. There is much work before us and much for us to teach. There is need for enthusiasm and the resources of a progressive people. Wemust be good witnesses of our profession. We must find the way to provide an adequate nursing service for all people; nursing, with its great past, has to get a greater future. First, we must have faith in our cause, which is both honorable and worthwhile. Secondly, we must supply the environment which will enable the nurse to fulfil her work in the broadest sense. Thirdly, the nurse's education must be both liberal, wise, and continuous. Fourthly, in our great gatherings, wemust be ambassadors of good will to other countries

Miss Vera Neih, of China, seconded the vote of thanks. She felt that the idea of "One World" was slowly, but increasingly, being appreciated by the peoples of the world, and that this



Citizens of "One World"

Congress would strongly aid the cause of friendship and world peace.

The business meeting opened with the roll-call. Thirty-three countries were represented, and as the name of each was called the delegate and members from that country rose in their places. The size in each group varied. from the large numbers from United States, Canada, and Great Britain, to the five from China, four from Denmark, and one from Chile. The countries represented were, in the order of calling: Great Britain-United States of America—Canada— Denmark — Finland — Netherlands - India - New Zealand - Belgium -China - Norway - South Africa — France — Eire — Poland — Brazil — Philippines — Greece — Sweden — Czechoslovakia — Hungary — Australia — Roumania — Switzerland — Chile — Palestine — Italy — Mexico — Colombia — Austria - Spain - Venezuela and

Turkey.

Miss Annie W. Goodrich (United States) then took the chair, while Miss Taylor, president, gave her address. "For ten years we have awaited your arrival," she said. "Our grateful hearts are lifted in thanksgiving that so many of us are here today. We charge you on your return to carry our affectionate greetings to those who could not attend the Congress." It was forty-six years since the American nurses had had the privilege of meeting, in the United States, their colleagues from distant lands, and the years since 1937 had left an indelible mark on all. She paid tribute to all those who made the supreme sacrifice, and to all who had done so much both in military and civilian nursing to make the world a better place. "All over the world," continued Miss Taylor, "there are too few nurses and the cause must be vigorously sought. To be sufficient and effective for a purpose demands the highest type of broad culture and experience. One of the primary functions of the International Council of Nurses is to interpret nursing in its essentials; it must be not merely a scientific skill but must also include

social understanding. Student nurses have the right to expect their education to prepare them to take their place in the community and not only in the hospital. In other professions today there are many opportunities and leisure to broaden the outlook on life; it is is not surprising that so many choose to enter one of these instead of nursing." Miss Taylor urged that we do not lose sight of the spiritual aspect in our truly great profession and vocation.

Dame Ellen Musson, treasurer of the International Council of Nurses, said she was very glad to hand over the accounts after twenty-two years. with no outstanding debts; she concluded by reminding the members that there must now be rapid expansion and additional work for the International Council of Nurses, so that members must face soon a corresponding rise in the per capita fee.

The meeting adjourned so that the members might visit the exhibits, which were described as among the most colorful ever assembled for a nursing convention. Manufacturers had brought to Atlantic City an estimated \$1,000,000 worth of equipment and displays of all that is new and of interest to the nursing Many foreign governprofession. ments participated, not only for the purpose of greeting their own nationals but also to extend to all visitors and delegates information about their respective countries. Among those considered by authorities to be outstanding was the Canadian exhibit, which depicted all the health services available for the Canadian family. A map showed the centres of population and the health services available in those centres. A particularly interesting feature was the pictorial presentation of the method by which medical and nursing personnel were flown to inaccessible areas by air ambulance.

The Government of New Zealand presented an exhibit showing photographs of the educational and recreational advantages for student nurses in that land of unexcelled outdoor sports. Nursing in Belgium and the Belgian Congo was the theme of the exhibit of the Belgian Government, while the exhibit of Switzerland was devoted to the Olympic games and winter sports pictures. Czechoslovakia's display was of nursing, while the Republic of the Philippines had examples of handicraft work to stress the efforts being made for the economic rehabilitation of its citizens, including nurses. From an educational viewpoint, it is doubtful if a more varied exhibit section has ever been assembled.

On Wednesday morning, May 14, the International Council of Nurses assembled to hear several prominent speakers on the subject of "nursing and world organization." Miss Killikki Pohjala, of Finland, who presided, remarked that there was one truly international word and that was "health."

Dr. Harold E. Snyder, director of the Commission on International Educational Reconstruction, stated that, although UNESCO was not the first effort of its kind, previous efforts had only received limited support. Many projects were being planned, from fellowships for specialists in war-devastated countries to youth service camps, to help rebuild schools and hospitals in such countries. Dr. Snyder ended with the plea that nurses should not isolate themselves from other citizens or from other teachers.

The Honorable Aake Ording, consultant on Fund-Raising, Division of Economics, Stability and Development, Department of Economic Affairs, United Nations, spoke of the splendid work which UNRRA had done and the nurses working with it. The present situation was a great challenge to the whole of civilization. "Do we not care that sixty million children should be hungry, though we have food?" asked Mr. Ording. The United Nations have decided that this problem of the children must be faced at once, even though other important matters have to wait. Between six and seven million dollars in foreign relief is needed, but this is not much more than two days' expenses of the United States, the United Kingdom, and Canada in the war. Five years of sweat and toil of the whole world for war: why not one day's toil for peace? The General Assembly has agreed to this proposal. "One day's work for one free world" is to be the slogan, and everyone in every country will be asked to give. Not only the nondevastated countries, but every country will give. The devastated countries agree to this, though some countries will receive more than they A world-wide effort will be made in the near future, and everyone will be given the opportunity of looking into that new world we talk of so much.

Sir Raphael Cilento, director of the Division of Social Activities of the United Nations, also addressed the assembly. After each great conflict, nursing and medicine have had the opportunity to develop greatly, but all these efforts would have failed eventually if we did not make this last opportunity a success. The cause of failure was isolation from reality in nursing, abstraction and isolationism that do not follow the trend of the time. "My message to you today is this," said Sir Raphael, "are you sufficiently free from those dangers? After the Crimean War there was Miss



China, Czechoslovakia and U.S.A.

Nightingale: after the 1914-18 war there came registration for nurses; after this war we have the opportunity of co-ordinating the nursing of sickness with that of public health and industrial nursing. We have to teach people how to live. Nurses do well to realize that nursing is not only a service for the sick but for the well. There has begun a process of specialization up and specialization down, but we must capture every field from the highest to the lowest and consolidate them into one plan, or we shall again go through a period of isolation from reality which will lead not to a new pinnacle, but to disaster."

Dr. William Sawyer, chief medical officer of UNRRA, gave a summary of the ways in which conquering peoples had in the past considered the health of the conquered. Now the doctor, nurse, and sanitary engineer are the essential workers among the team of many. Dr. Sawver predicted that the broad objectives of the World Health Organization would permit development in future health organization and activities unthought of before, and that nothing could hold it back so long as international co-operation was maintained. "Nurses will have a large part to play in the development of health, which will be continued in the more propitious days of peace," the speaker concluded.

On Wednesday evening, May 14, members gathered in the Assembly Hall for the Florence Nightingale oration. Mrs. Lucy Seymer, a graduate of the Nightingale School of St. Thomas Hospital and former librarian of the Royal College of Nursing, gave the oration. It is our sincere regret that nurses everywhere could not have shared this experience. Seymer has an extremely charming and attractive personality, and her musical voice made listening a sheer delight. It was plainly obvious to her spellbound audience that much hard research work had gone into the preparation of one aspect of the work of Florence Nightingale, namely, her writings. We later learned, what we suspected was true, that Mrs. Seymer had spent many long hours during one of Britain's most trying winters searching out records in the chilly atmosphere of the British Museum, with often only the light of a candle to carry out her extensive searching and reading.

Mrs. Seymer chose the writings of Florence Nightingale as the subject of the oration for this Congress because they are greatly underestimated and because, in them, Florence Nightingale reveals herself completely. The Florence Nightingale International Foundation proposes to catalogue everything connected with Florence Nightingale and all she wrote, and this will greatly facilitate the work of future students.

Mrs. Seymer went on to give a most lively survey of the writings and said that Florence Nightingale was a great "debunker"; her writings were trenchant but never scurrilous or personal: her notes on matters affecting the hospitals, health, and efficiency of the British Army were the greatest written indictment of stupidity. The most marked characteristic of the writings was their absolute lucidity—"lucidity might be synonymous with dullness. but 'dullness' can never be applied to Miss Nightingale." Her governmental writings are clear and unemotional, but here and there contain a sly "dig," such as, when criticizing a government report which referred to "inconvenient overcrowding," Miss Nightingale queried "What is convenient overcrowding?" "Humbug was her greatest enemy, and to shams and muddled thinking she was merciless," declared Mrs. Seymer. "She is breath-takingly modern and states that the frequent definition of a nurse as devoted and obedient would do well for a porter or a horse, though not a policeman."

"Was Florence Nightingale a great writer? She would have deprecated this title, as she would rather live than write; she wrote because she must. Her influence was unparalleled after the Crimea and she felt she must use it," Mrs. Seymer continued. Her versatility was as overwhelming as the sheer amount of her writings; but much was never published, and much was only printed privately. writings can be grouped under four headings: reports; writings on hospitals and nursing; philosophical and religious writings; and works on India. In addition to those are her innumerable letters, most of which are unpublished. Her Notes on Nursing were first published in 1859. It was her only book solely on nursing and was a best-seller of its day—15,000 copies being sold at five shillings each in a month. This publication was a bombshell and enunciated the principles of the nursing profession for the first time. Mrs. Seymer went on to mention briefly the writings in the other three groups, and finally said that a study of Miss Nightingale's published works furnished a truer appreciation of her personality and intereststheir study was a most important spiritual refresher course in the fundamentals of nursing. "As a graduate of her school," said Mrs. Seymer, "I bring this oration to a close with the knowledge that we are only on the threshold of nursing. In future may a better way be opened."

The nurses of Canada will be glad to learn that the International Council of Nurses announced at the closing session that the Florence Nightingale oration, prepared and given by Mrs. Seymer, will be published in suitable form for use in reference libraries.

Following the oration, Miss Effic Taylor made a presentation to two women who had made their mark in the international nursing world. After reading the citations, she presented a jewelled pin with the Council's insignia, and illuminated scrolls, to Miss Annie W. Goodrich, for her amazing versatility and inspired, effective leadership in nursing education; and to Miss Lavinia Dock, secretary to the Council for twentyfour years from its inception—"one of the greatest spirits that ever moved in our midst, for her invaluable contribution to nursing and international progress." Miss Isabel Stewart announced that, in appreciation of the wonderful work and life of Miss Dock, some friends had created a fund in

her honor, to be presented to the International Council of Nurses to symbolize her generous spirit. The fund amounted to three thousand dollars and was still open. It was to be used for supplying educational materials, translating books, and supplying equipment and film strips through the International Council of Nurses.

Before a huge audience in the ballroom of the Assembly Hall, the Ninth Quadrennial Congress of the International Council of Nurses came to a close with the giving of the watchword "Faith" by the retiring president, Miss Effie J. Taylor, and a welcome to Sweden in 1949, given by the new president, Miss Gerda Höjer.

Miss Grace Fairley then submitted the resolutions which had arisen out of the Congress, all of which were carried unanimously. The resolutions were as follows:

- 1. That members pledged themselves to support the appeal of the Honorable Aake Ording, of the United Nations, for relief work for the children throughout the world.
- 2. That the International Council of Nurses considered themselves a positive force in supporting international bodies working for world peace and the welfare of mankind.
- 3. That national organizations, able and anxious to assist those national organizations in need, should be authorized, through the International Council of Nurses, to assist in their professional needs, such as teaching equipment, books, publications, etc.



Gerda Höjer and Esse Taylor

- 4. That there was a crucial need for nursing and other personnel in health services and as there was no single or immediate solution to this problem, therefore, the Council called on all people of good will to seek a remedy for this shortage, and they called particularly to young women to enter the service of mankind in this way.
- 5. That, as the quality of nursing and the numbers depended partly on the satisfactory circumstances and conditions under which nurses must work, the International Council of Nurses urge the development of the national association as the most suitable spokesman on salaries, conditions, etc.
- 6. That the International Council of Nurses offer its gratitude to the American Nurses' Association for the financial support of headquarters during the war years.
- 7. That, in recognition of the outstanding work of Miss Taylor, president of the Council for ten years, honorary membership be conferred upon her, and also on Dame Ellen Musson, who has given up her post as treasurer this session; that a vote of thanks be

made to Mrs. Seymour, of the National League of Nursing Education, for the Adelaide Nutting Plaque, and to friends of Lavinia Dock for funds; also to all organizations and people who had helped to make the Congress a success, particularly Miss Anna Schwarzenberg.

Miss Anna Schwarzenberg reported that the grand total of members in attendance was 6,592; they came from 39 countries other than the United States of America, with 748 members

from these countries.

The officers elected were as follows: President, Miss Gerda Höjer (Sweden); first vice-president, Miss M. Lambie (New Zealand); second vice-president, Miss K. Densford (United States); third vice-president, Miss G. Fairley (Canada); treasurer, Miss G. E. Davies (Great Britain).

GERTRUDE M. HALL General Secretary-Treasurer Canadian Nurses' Association

Professional Organizations and Nurses' Working Conditions

GERDA HÖJER

Every graduate nurse knows that our national nurses' associations are formed with the primary purpose of gathering all graduate nurses in each country together. In this way we are made aware of the need for unity in developing health schemes and nursing in our country, and the need to help each other to follow the rapid evolution of this service through continuous self-education.

We have laid this enormous burden upon ourselves as citizens in a democracy. In a democracy, as you know, every citizen is responsible for his or her part in the forward development of their community.

We organized this portion of the work of the association by making suggestions and even by taking the necessary steps regarding the schools of nursing and the post-graduate education to keep them ahead of, or at least abreast of, other educational institutions; by studying and sending reports to the proper authority regarding proposals to new laws attaching social conditions and nursing activities; by trying to persuade the authorities to appoint nurses to committees for research work of this kind; by observing the practical functioning of laws and by giving statements to the authorities if necessary; by holding lectures, meetings, discussions, and courses. For these reasons the national organizations of nurses all over the world have united into the International Council of Nurses, and the associations of the five northern countries of Europe into the Northern Nurses' Union.

Our second reason for organization is to bargain for better hours and working conditions, living conditions, and salaries—in a few words—employment conditions, to ensure that they correspond to the standard of other professions in our own and other countries.

We take up this problem at this time because the nursing profession, at least in the northern countries of Europe, always has been and still remains a charity work not paid a decent salary, etc., and we find this very unfair! And because—it is a very great problem of today—the young girls of the calibre we urgently require are able to find so many other social and human professions which give them not only satisfaction but a remuneration in accordance with their ability and at the same time require less strenuous working hours than does the nursing profession. Of the greatest importance to any profession is the quality of the young people who are engaged.

In Sweden we discussed, in 1934, the question of our group's economical standard. We are firmly convinced that we can never succeed in our first purpose if we are not successful in our second.

Now I have come to the important part of the question: our employment conditions. So far as I can see they might be dealt with in at least two ways:

The first way: The association should proceed with some research work to determine employment conditions among nurses, perform a comparison between this and other professions, and by law acquire the right to discuss economic questions with the employers, performing this task for all members regarding salaries, annuities, compensation for eventual higher cost of living, holidays, working hours and how they are planned, compensation for night duty, repayment for residence, food, laundry, etc., pensions, if necessary. In other words, the association shall regulate employment conditions by bargaining with the various employers.

The second way: The association should proceed with some research work to determine employment conditions among nurses, should perform a comparison between this and other professions and, in the professional journal, publish the result and relate the conditions under which the association advises the nurses—in other words—a guide for its members.

In a country with a political structure such as Sweden, we will not have any progress through the second way. We experimented with this method until 1934, by which time we were at the bottom of employment conditions, and we at last united our forces and began the struggle.

The political structure of a country has a great influence on maintenance of proper conditions, because the trade unions for all their handicraft workers in a country of Sweden's political structure for years have kept on bargaining every other year-and now each year-to increase their wages, while the salaries of the professional workers are strictly outlined and remain in a code of rules altered every tenth year. The difference between the conditions for professional and other workers has up to the present time been that, in the first instance, the worker cannot be dismissed if the worker has not done something wrong in service; in the second instance, the worker runs the risk of being discharged at the end of every contract. In reality it is quite the same for both groups as the trade unions do not allow dismissal if they possibly can avoid it.

The members of the different professions see their salaries gradually decreasing while those of the workers are on the rise due to the right to bargain under laws suitable for them. In Sweden various groups obtained the desired law—in 1936, regarding professional workers employed by private agencies; in 1937, for those employed by the state; and in 1940, regarding professional workers employed by the communities, municipalities, etc. As most nurses are employed by communities, etc., in Sweden this law was for the nurses the most important, so I will explain briefly what it contains:

- 1. The right for employees with official responsibility to bargain with a municipal, parish, or community authority.
- A bargain may take place on questions concerning general employment conditions, working hours, salaries, and how a contract is applied.
- 3. An association which wishes to engage in bargaining for its members is required to apply for the right to the Social Department. The association shall give all details concerning constitution and by-laws, who are members of the various boards, the number of members there are and by whom they are employed, etc. Every year the association has to send the above-mentioned details to the Social Department. If extensive changes have taken place in the meantime, the association should report it at once. All published material shall be sent to the department.
- 4. An association does not obtain the right to bargain unless at least 50 per cent of the profession in question belong to the association.
- If an association has obtained the right to bargain on the grounds of registration and wishes to use his right towards, e.g., the city

of Stockholm, this association is required to inform the municipality in writing and forward all the necessary details, including the number of members engaged by this city. A copy of the registration act in some cases is enclosed with the above information.

- 6. On receipt of the above, the municipality is compelled to send proposals regarding employment conditions to the association before decisions are made. The association may ask for bargaining in writing or by requesting an audience.
- 7. Neither one nor the other has the right to delay a question.
- 8. Time and place for the meeting is decided by the municipal authority and they appoint the officers. Minutes shall be kept and both groups are responsible for the accuracy of them.
- 9. Any elected professional worker has the right to attend these meetings and cannot be restrained by the employer.
- 10. The minutes from these meetings shall accompany the question to the highest municipal authority.

In the law concerning state-employed professional workers the cabinet may on application, from the authority or the association, elect representatives to bargain with the association.

The Swedish Nurses' Association began to bargain with the nurses' employers before the law was passed. We had the proposals for the new law and made some important alterations, but the idea came from a federation of a number of professions, of which our association was a member.

We applied for bargaining rights as soon as this was possible. Our proportion of members in the association, in relation to active nurses in Sweden, has not varied during the last few years. At the conclusion of the year 1945 more than 92 per cent of the active nurses in Sweden belonged to the association. We obtained registration as a bargaining association with state-, municipality-, etc., employers. This right implies that both the national association, the control board, and the local branches, i.e., the twenty-six branches of our association in our country have bargaining rights. The Swedish Nurses' Association's Grand Council has decided that no bargaining shall take place unless consultation has preceded with our headquarters. If possible, one from the headquarters shall take part in the bargaining. This co-operation has proved satisfactory.

First, we had to increase salaries for nurses nationally to the same level for each specialty independently of the employers. It resulted in the rural districts' salaries being 16 per cent lower than salaries in Stockholm. We have, at present, five classification for salaries, based chiefly on the living conditions of various areas-4 per cent between each one, which makes a difference of 16 per cent at the most. Only 15 per cent of the nurses in Sweden are employed by the state. The city of Stockholm has approximately the same percentage of nurses as the state and the provinces employ close to 45 per cent. The state-employed nurses and those employed by the city of Stockholm are the highest paid nurses. was very important to the association to have the salaries increased for the nurses employed by the provinces, as they are the largest group and thus control the salaries of all the nurses in Sweden.

Our aim was to secure the same employment conditions for nurses as for other professional workers in comparable positions. One could discuss the question at length of which profession is of the same character, etc., as that of the nurse without coming to a proper conclusion. We find that several points should be considered in establishing the salaries for nurses: The demand and supply for qualified aspirants to the schools of nursing; the length, cost, and quality of the training; the type of work, responsibility, financial liability for anything which might happen to the patients; working hours.

Taking all of the above-mentioned requirements into consideration, we have found that a nurse should obtain a salary in group 12-16 in the present salary scale. It was necessary to bargain, in the beginning, for the 70% of the nurses, who were paid the minimum salary, in order that they would eventually reach the higher level. In 1937, the minimum salary for a staff nurse employed by the provinces was 64% of the one employed by the state. A head nurse in the provinces received only 58% of the salary of a head nurse employed by the state and 70% of that of a superintendent.

In 1939 the proportions were as follows: The maximum salary of a staff nurse in the provinces was 75% of the one employed by the state, the minimum salary was 72%. The maximum salary for a head nurse was 72% and minimum salary only 57%, while the maximum salary for a superintendent was 76% and the minimum salary 73% be-

tween 1939-1945. During the war years we did not have any changes in the salaries.

Commencing January 1, 1947, the salaries for nurses in the provinces were about 5% higher than the one for a state-employed nurse. We have accomplished this only by bargaining. The above-mentioned percentages do not reveal the increase of the salaries on a percentage basis as we have, during the last number of years, obtained an increase for nurses employed by the state.

We have not yet had time to bargain for the last increase with all employers, who engage only a few nurses. They will have to increase their salaries, if they wish to obtain the nurses. Before I left Sweden we had already commenced discussion with about half of the above-mentioned employers. The nurses were informed in our nursing publication that they should not accept salaries below a certain standard. Practically all new positions are advertised in our publication and there we are able to control the amount by bargaining if the salary as advertised is insufficient.

When bargaining, as far as salaries are concerned, we investigate very thoroughly employment conditions. In these questions I think that our authorities are a little more advanced than in most countries. In most cases nurses can change positions and still maintain their annuity. This is according to special requirements established by the Health Department for those who wish to belong to the state professional pension system. For all these special requirements we are grateful to our first superintendent in the Health Department, Miss Kerstin Norden-Another requirement is that every nurse on a staff, commencing the first year, shall have a holiday of thirty days a year. The state is the only employer for whom exceptions can be allowed. You are not allowed to dismiss a nurse because of sickness regardless of the nature of the disease. After four years of continuous illness one is eligible for a pension, which shall at least be three-quarters of the professional pension. But there are requirements also for the nurse. If she wishes to withdraw, she is required to give three months' notice. If she can find a substitute. they will let her go earlier. As an association, we endeavor to force the employers to join this pension system, according to the requirements. We have been very successful in this question. Nearly 100 per cent of the Swedish nurses belong to one of the pension systems.

In the last years we have discussed the question of working hours and we have obtained a satisfactory negotiation with our provincial employer, that the working day shall be an eight-hour day with one day off per week—as soon as possible. We have not yet been able to obtain pay for overtime, but we all have the one day off a week or it may be added to a holiday period. In all our work for better conditions we have had excellent assistance from our Health Department.

As mentioned before, the laws for the professional bargaining rights were proposed by a federation of different professional associations. In 1946, we joined this federation, which has at present about two hundred and fifty thousand members, teachers, engineers, etc. Together with representatives from this association we now bargain for better general conditions, such as annuities, pensions, etc. According to our country's principles, all professional men and women in Sweden shall have the same salary for the same work. Nevertheless, we have many underpaid women in the business professions and nursing is one of these. In order to solve these questions we have this federation. In correspondence addressed to our Cabinet we have asked for investigation regarding this question. A committee is now appointed with a suitable female representation.

In the correspondence with the Cabinet—not only from our association but from the many other associations—we have now formed a committee which is investigating the professional workers' pensions in relation to their salaries. We expect a proposal on the subject next year.

A committee, appointed by the Cabinet, has studied nurses' salaries. We worked nearly two years. The study included all nursing staffs and lower economic workers in hospitals, i.e., maids. Of the members of this committee four were of the opinion that a head nurse should be in group 9-she was already in group 7. One member came to the conclusion that she ought to be in group 12. Another member thought group 8 quite sufficient. All experts-the Health Department, the State Education Committee, the Hospital Board, the Doctors' Federation-favored group 9 as the lowest we should consider, most of them being for group 11 or 12. The Cabinet proposed to the Parliament, in January of this year, group 9. The Parliament, where most of the members belong to the provinces, decided on February 24 on group

8, which was the salary for the head nurses employed by the provinces according to our last negotiation. The nurses in Sweden have today 85 per cent of the salary we find fit for them.

What do you think the nurses in Sweden are doing now? As soon as the decision was taken by the Parliament, the state-employed nurses from our large hospitals in Stockholm wrote to the association and asked for action. The nurses gave in their resignations to the association. The association called a public meeting, where all the details were put forward for the public, and the meeting concluded in favor of the nurses. All the daily papers had articles from this meeting—here again in favor of the nurses. Since that time the daily papers of different political colors have published articles illustrating the inadequate salaries paid to nurses.

The Board of the association was immediately called to an interim meeting with representatives from the big professional federation. We are informed by and have conferences with this federation before any action or decision is taken. This is of great assistance.

The Board of the hospitals has now called a meeting to study the methods of bargaining. If the association gives in the resignations, it does not mean that the patients shall be without nurses. Nurses have, as before mentioned, been required to give three months' notice. All would be willing to remain if the salaries are adjusted. Bargaining will commence very soon to study the salaries and better working conditions. This little group of approximately 15 per cent of active nurses fight for all the others, as they advise the amount of the salary for them. In the last number of our journal the Board of the association asks all members to give 20 Swedish Crowns, that is, a little more than \$5.00 each to support the action.

What do we gain by this action? We are sure to get overtime pay for this group of nurses, higher salaries for nurses on night duty and on watch—we might be able to get salaries according to the proposal of the Cabinet. Even if we only obtain a small raise this time, we have the possibility of having the question reconsidered at an earlier date than if nothing had happened.

If a question goes steadily forward the bargaining rights are used when necessary, perhaps every other year. I have taken the last and the most official action of our bargaining as an example to show how one, in order to improve salaries, has to bring the various authorities into co-operation, as well as follow the question and use the bargaining rights just at the right moment.

International Education of Nurses

ETHEL JOHNS

We shall consider the manifold responsibilities which the International Council of Nurses may reasonably be expected to assume with respect to the *international* education of nurses. Before proceeding further, it may be well to attempt to clarify the meaning of this rather ambiguous and obscure phrase. What relationship is there between *international* nursing education and nursing education in general? Why is the qualifying word "international" used in this connection and what are its implications?

Reduced to its simplest terms, international nursing education implies that nurses seek and find opportunities of learning something about nursing in countries other than their own and, since education is always a two-way process, it follows that the countries in which these opportunities are sought must be willing and able to make them freely available. This urge to go far afield in search of knowledge has always been characteristic of nurses. Florence Nightingale herself set the example. At first these adventures followed no formal pattern but were independently undertaken by the individuals directly concerned. But as the profession grew in numbers and travel became less difficult, nursing leaders in many countries realized the desirability of more frequent and direct contact and, in response to a felt need, the International Council of Nurses came into being.

From the very beginning, it was apparent that the I.C.N. was keenly aware of its edu-

cational responsibilities. One of its stated purposes was to enhance the usefulness of the nursing profession by expanding and improving the educational opportunities afforded to its members and, at this point, it may be illuminating and encouraging to review the many ways in which this purpose already has been fulfilled. The successive congresses held at regular intervals in different countries made it possible for nurses from all parts of the world to meet in congenial surroundings and to take counsel with one another. The distinctive culture and traditions of the various national groups which extended this hospitality served as a rich and colorful background for the more formal deliberations. Slowly but surely differences in race, language, and creed lost their significance and we began to realize that the bond of our common task transcends them all.

We also learned to like and trust one another by working together on the committees which were set up to explore and compare educational standards and methods in the member countries. Qualifications for membership in the I.C.N. were formulated and proved to be both an incentive and a stimulus to newly-formed national organizations which were eager to achieve international recognition. No attempt was made to impose fixed educational requirements or methods upon schools of nursing in any country but, thanks to the excellent work done by the Committee on Education, acceptable standards for the basic training of nurses were agreed upon and served both as a pattern and a measuring-rod. Only those who have had the privilege of observing the results of this untiring effort in many countries and over a period of years are in a position to assess them at their full value. The foundations have, indeed, been well and truly laid.

As time went on, the educational activities of the I.C.N. were brought more sharply into focus by the enterprising executive staff at headquarters. The I.C.N. Review appeared, skilfully edited in three languages and beautifully printed. This professional journal proved a most effective educational tool as well as serving as a link between the member countries. For a time it almost seemed that we were ready to go forward together into an unclouded future. Then, in 1939, the shadow of the Second World War darkened the sky. But even in the darkest hours the flame which we had kindled was never utterly quenched.

There were those in every country who guarded and cherished it. The I.C.N. owes a great debt to its president, Effie Taylor, who, through the long years of strife, managed to keep in touch with her colleagues in many lands in spite of obstacles which might have daunted a less gallant and loving spirit.

Now, the International Council of Nurses once more realizes its forces, closes its ranks, and prepares to tackle the new and challenging tasks which lie ahead. First of all, close contact must be established with the United Nations and other associated organizations, such as UNESCO and the World Health Organization, which are now engaged in building a new world upon the ruins of the old. The I.C.N. will thus be able to function in an educational capacity as the interpreter and representative of organized nursing in all parts of the world. The headquarters of the I.C.N. will be a clearing-house for information concerning the activities of these powerful international agencies and will promptly relay it to the member countries by means of the I.C.N. Bulletin soon, we hope, to blossom out in all its pre-war splendor.

The I.C.N. will also look with confidence to these international agencies for help and guidance in setting up more far-reaching policies with respect to nursing education. Demands for service are already being made upon a scale so vast that we must be able to count upon the support and sympathetic understanding of those whom we are to serve. Co-ordinated planning upon an international as well as a national scale will be indispensable and we should be ready to present a full and accurate appraisal of our present educational resources as well as to submit a frank estimate of the extent to which they are, or are not, adequate to future needs. The I.C.N. is in the fortunate position of being able to obtain, analyze, compare, and assemble the information which the World Organization will want to receive. If we can prove at the outset that we are capable of participating in world affairs there can be no doubt that we shall be permitted to do so. No other group of women enjoys a similar opportunity. We should not fail to take full advantage of it.

The approach of the atomic age brings a promise and a threat which did not exist prior to the war. Already it has led to discoveries in the field of medicine which make it imperative that nurses shall acquire new

knowledge and develop special skills. If there were no other challenge than this, there would be no need for dismay. But if the disasters which destroyed Hiroshima and Nagasaki were to devastate our own or any other country the nursing profession would be obliged to accept heavy responsibility. The task of preparing its members for this ordeal rests squarely upon the shoulders of the International Council of Nurses and the national organizations of which it is composed. No country will be immune. Political frontiers are no barrier to radio-activity. Neutrality and non-belligerency are no defence. Distance is no shield. We should all be under fire, military and civilians alike. Every branch of nursing service would be called up immediately. Highly qualified teaching personnel and special equipment would have to be accessible to whatever military and civilian authorities were in command. There is, of course, every reason to hope that no such emergency will ever arise but that is no excuse for neglecting to study ways and means of dealing with it. Here is another instance of the paramount importance of maintaining close touch with the international agencies which have already been mentioned. Unless our efforts mesh with theirs we cannot be effective in so widespread a calamity.

Now let us turn to other and happier prospects. If all goes well (and we must hope and believe that it will) the International Council of Nurses will resume forthwith the peaceful tasks in which considerable progress has already been made. Educational standards will be re-examined, modified, and strengthened. The excellent work already done by the Committee on Education in connection with basic nursing will be carried over into the post-graduate field and, as a result, there will be a rapidly increasing demand for opportunities to travel, study, and observe in all the member countries. This is certainly a situation in which the I.C.N. can render valuable assistance, first by evaluating the educational resources which are available and then by issuing information concerning them to the member units. No country has a monopoly of all that is good in nursing and, since the I.C.N. is made up of units great and small, it is not likely to make the mistake of considering sheer size to be the only criterion of excellence.

There is yet another guiding influence which the I.C.N. might well exercise, especially for the benefit of those of us who live in

the tide of travel will flow in our direction and we should be keenly aware that living, working, and studying in other countries than one's own is not as simple as it sounds. It might be a happier and more profitable experience if the climate, in more senses than one, were more temperate and genial. Within the friendly orbit of the I.C.N., we Anglo-Saxons might learn that there are better ways of overcoming the barrier of language than by shouting a little more loudly in English. While we can never emulate the deceptive ease with which our European and Oriental sisters glide from one foreign language to another, we might try to master the rudiments of one. It might also create the sort of climate which our visitors would enjoy if the I.C.N. could help us to understand how it feels to work in a physical environment which is sometimes uncongenial and always unfamiliar. We ought to know from experience how miserable it is to eat queer food at unusual hours. Americans should be compelled to drink English coffee and the English should be compelled to drink American tea without visibly shuddering. On this side of the Atlantic we should remember that the Latin races consider corn on the cob to be unfit for human consumption and are surprised to find it on our dinner tables. Visitors from the Balkans who delight in scattering caraway seed over cabbage and ice cream should be allowed to do so without invidious comment on our part. As Kipling said, "God be praised for the infinite diversity of his creatures." It makes life much more interesting. Foolish trifles? Well, perhaps, but nevertheless these are the intangibles which, mingled with one another, make up the subtle essence known as climate.

Anglo-Saxon countries. For a time at least

The I.C.N. should also remind us that our visitors might be able to teach us something if we could ever stop talking long enough to listen to them. Furthermore, we should realize that it might be well freely to admit our own failures for they certainly will not escape the vigilant if friendly eye of the foreign observer. The officers of the I.C.N. frequently have an opportunity to talk with visitors who have just returned from a sojourn in our midst. It might be salutary if disconcerting to be told that the quality of our teaching was not judged in the classroom alone but was subjected to a sterner test at the bedside of the patient. The records which seemed so impressive in the office of a public health nursing agency may have seemed a

little unreal to the visitor who compared them with the sort of work she observed out in the field. After all, educational education is, or ought to be, a two-way process. Why not expose ourselves to it occasionally?

And now brief reference must be made to an educational responsibility so heavy that it outweighs all the others. In setting up a Committee on Ethics the International Council of Nurses tacitly admitted that the scientific and technical content of nursing education must be blended with some instruction concerning moral and spiritual values. During the past few years nursing morale has been undermined to some extent. Our patients do not complain of an occasional lack of knowledge or skill on our part. The trouble goes deeper than that. The callous attitude, the blank indifference with which some nurses regard them is far more wounding. Perhaps it is unreasonable to expect that nurses shall altogether escape the weakening of the moral fibre which is apparent in the community at large. But are we compelled to adopt the graceless manners and vulgar speech which seem so out of place in the presence of anxiety and suffering? Should not every patient be treated with the courtesy and respect which imply recognition of his dignity and worth as a personality in his own right?

Where are we to look for a remedy? The harsh military discipline of the old days has crumbled and is not likely to be restored but, in spite of its stupidity and arrogance, it did make for law and order by imposing certain restraints over behavior and speech. As a professional group, we are bound to seek a more excellent way and to set up controls which replace the arbitrary and inflexible discipline which is inherent in the military system. The International Council of Nurses, in co-operation with its national units, could and should provide the positive and enlightened leadership which is necessary to the preservation of our professional integrity.

It has been shown that the International Council of Nurses has certain specific responsibilities with respect to the international education of nurses and, by way of summary, these may be re-stated as follows:

1. The establishment and maintenance of close and effective relationships with all inter-

national groups associated with the United Nations which are engaged in promoting the health and welfare of mankind:

- 2. The maintenance and improvement of the standards already set in relation to the basic education of nurses.
- 3. The formulation of acceptable standards for post-graduate education and the encouragement of the interchange of nurses between the member countries for purposes of study and observation.
- 4. The development of strong and fearless leadership which will ensure the preservation of the moral and spiritual values which are the very soul of nursing.

Over and above all these, there is yet another educational responsibility which, through the years, the International Council of Nurses has never failed to fulfil. We have demonstrated by force of example that it is possible for people of different races, creeds, languages and political beliefs to work together and, in a measure, to understand one another. The I.C.N. has steadfastly refused either to be influenced or dominated by any political ideology whatsoever.

The links which bind us together have survived the atrocious tensions of two world wars and a whole series of economic depressions. There have been quarrels, rivalries, petty frictions, because very few of us are quite ready to become citizens of the world and we cling to the beloved country which is our very own. But we are learning. Slowly but surely, we are becoming convinced that international unity and peace does not only depend upon formal treaties drawn up by the heads of governments but also upon the determination of certain groups to keep their international solidarity intact. Among these, nursing is one of the most powerful because the service which we alone can render is given in response to universal need. We have the high privilege of giving it to our enemies as well as to our friends. What else have nurses to offer? Very little that is tangible. Most of us work all our lives for little more than a living wage. Yet, as we look upon the International Council of Nurses to which we all belong, we can claim in pride and in humility that we have brought the honor and the glory of the nations into it.

The errors of vesterday will pave the way to successful tomorrows if we can make a ladder of our mistakes rather than a grave.

—J. H. Thomas

Post-Graduate Education

MARY S. MATHEWSON, B.Sc.

In approaching this topic, I have not prepared an elaborate survey of post-graduate education in the countries represented in the International Council of Nurses, nor even in my own country. In the first place, the elapsed time since I was asked to speak to you was much too short to permit such a report and, in the second place, I have a strong feeling that the survey approach to this topic would not necessarily throw much light upon the way ahead. I think, perhaps, that we on this continent have placed too much faith in surveys and used the term loosely for all and sundry studies. I well remember a noted English visitor who spent some time in our city at the peak of the survey era whose farewell comment was "I shall always think of America as seething in surveys."

Some good undoubtedly comes out of a well-directed survey which has strong, clear-cut recommendations, particularly if these are implemented. Too many of them perish at the fact-finding stage, unfortunately. With this conviction in mind I have tried to put together a few thoughts which I hope may provoke helpful discussion.

Although as old as womanhood, nursing is a very young profession and, like all youthful things, its development alternates between periods of rapid growth and periods when little progress is visible but the organism seems to be gathering strength for a new forward spurt. Tremendous changes have taken place in the social and economic structure of the world since the war began. There have been rapid advances in medicine and in allied fields. Many new and exacting demands are being made upon nurses in old fields while many new opportunities and responsibilities point to the need for a reconsideration of the role and the preparation of the nurse today. Because we are so ambitious for our chosen profession we are disturbed by the present situation in nursing. Within a brief span of years, we have seen the pendulum swing from mass unemployment to incredible shortages. On all sides there are insistent demands for more hospital beds and for more public health nurses. The continued and increasing shortage is disillusioning to a public which learned to have a new respect for nursing service during the war years, particularly at a time when the world is trying to find health and peace and

nurses are needed as never before. From some quarters come strong recommendations that the nursing course be shortened and that entrance requirements and standards be lowered in order to produce more nurses quickly. At the same time there is dissatisfaction in the profession itself and much heart-searching as to whether or not we are more interested in the bait of shorter hours and higher wages held out by labor organizers, or whether we wish to remain a self-directing professional group. Let us remember that we deal in human lives and the happiness and well-being of individuals, families, and even of nations. It is a business which for some branches of the service must go on for 365 days each year, 24 hours each day, statutory holidays and weekends included. The overtired nurse cannot give her best and, therefore, we must seek to prevent overworkbut do not let us say "40 hours a week and overtime, or else!"

It is time that nurses themselves, who best know nursing, decide what can and must be done about all these matters or the decisions will be made for them. The situation is undoubtedly critical but let us accept the fact that this is an emergency. As our British sisters might say, we must not be "panicked" into making hasty decisions which might undermine our very foundations and which we would undoubtedly regret. On the other hand we must be open-minded and willing to make essential changes. Clear thinking, cool heads, long-term planning, and courageous action are certainly needed.

In glancing back over the story of our development, wars and their aftermath have provided the needed stimulus for tremendous changes in nursing. The Crimean War crystallized the work of Florence Nightingale and the training school was born. The Civil War in the United States of America precipitated a parallel development there. The war of 1914-18 forced the expansion of public health nursing and also fanned the feeble flame which at the turn of the century had produced the first university department of nursing and the first post-graduate course for nurses. With the post-war impetus, and on the insistence of nurses themselves, the number of such courses reached unbelievable proportions?

It seems inevitable that the end of the recent conflict should mark another turning point in our history. It is very fitting, therefore, that we take counsel together at this particular time if we are to come out of the present chaos into the promised land of nursing, with true professional status and a workable plan for providing nurses to give and direct the best possible nursing service for all who need it.

But what has all this to do with postgraduate education, you may ask? If we desire to change the pattern of nursing this can only come about by means of education. If we wish the effort to succeed it must start not only with the beginners but at the same time with those who are to be instrumental in bringing it about, that is, their teachers and directors. Where can they be reached in order to prepare them for that task except through post-graduate education?

Fortunately there is much hope for the re-education of adults. In our generation we have seen it done with tragic effectiveness for undesirable ends. Surely even more effort can go into a program with such a worthwhile goal.

In facing any problem it is often of tremendous assistance to learn how the same or a comparable problem has been dealt with by someone else, the methods used, and the results obtained. In our present situation let us look for a minute at Denmark. During the last century Denmark found herself in a desperate plight economically. relatively short space of time, life in Denmark was completely transformed and the Danes became a prosperous and progressive agricultural nation. This change was brought about by an excellent adult education scheme which did not teach the Danes to farm well but which roused in them such an irresistible desire to do so that the whole way of life in Denmark was completely changed as a result.

It seems to me that there is a very practical lesson for us in the Danish experience. Let us imagine that our nursing situation today is comparable to mid-nineteenth century Denmark. Instead of concentrating on an agricultural program we are vitally interested in a nursing development.

There are very few, I should judge, who believe that the basic course in nursing can produce nurses who are sufficiently qualified for all branches and all levels of nursing responsibility. Much is being done to broaden the basic course but if results are to be pro-

duced, in a reasonable time, it is evident that continuing education for those already in the field is equally important. It is such continuing education which we mean today when we speak of post-graduate education which our French confrères call "cours de perfectionnement," a very apt designation.

Reduced to its simplest terms, post-graduate education means simply education after graduation. What such education may be will depend to a large extent on what the education before graduation has been. Broadly speaking, it may include everything from staff education or "in-service" education to the most advanced curricula in university.

Even the terms, graduate and undergraduate, may be interpreted differently in various countries. In my country, for example, the term undergraduate when applied to nursing education means the basic course whether in a school conducted by a hospital or a university. Post-graduate may mean anything beyond that level. In other countries undergraduate may be applied to the basic course but is also used in referring to courses leading to a bachelor's degree, even for those already graduate nurses. The term post-graduate or graduate course is used for advanced courses in clinical specialties as well as for those programs beyond the bachelor's level, that is, leading to a master's degree or a doctorate. Whatever our interpretation may be we must define what we wish post-graduate education to do for nursing and then ask ourselves whether the tools and methods now used are producing the desired results and if not, why not?

As Aristotle commented long ago, "In education it makes all the difference why a man does or learns anything." What are our motives? If they are merely more prestige, a higher salary, another degree, then perhaps they are fulfilling these purposes to some extent. If, on the other hand, we are concerned with the development of the truly professional nurse and with meeting community needs we cannot be complacent.

Much of what is now offered in the name of post-graduate education is virtually technical education which is designed to prepare one for a job and thus to earn a living. If we believe that the true purpose of education is to develop human beings who have learned to see, to hear, to feel, to think, and to use their native abilities, most of us will agree that in general our present methods do not produce the desired ends.

Too many of our courses are collections of isolated subjects with the emphasis placed on giving factual information to students, many of whom do not want it. Much of it is of doubtful value to them, yet results are frequently measured in terms of the information acquired rather than the degree of intelligence and the idealism roused.

Too often there is a lack of balance between theory and practice. Someone has said, "Without theory practice is unintelligent—without practice theory is not understood." Certainly in nursing, theory without some actual experience is educationally wasteful and unsound. The adult with experience of life and the nurse who has practised her profession are much more able to profit by educational opportunities.

In spite of this, many of our inexperienced nurses are encouraged to enter post-graduate courses immediately after the basic course and frequently flit from course to course as they become increasingly remote from the practical application of their theory. Much more emphasis should be placed on the importance of gaining experience before proceeding to further courses which would then take on a new meaning.

Enough has been said and written about staff education that it will not be elaborated here except to say that no progressive nursing group, whether in or out of the hospital field, can afford to remain for long in a service where a good staff education program does not exist.

The development of other forms of postgraduation education in general has followed a pattern which is found in most countries in greater or lesser degree. It is interesting to note that, with few exceptions, facilities became available as the result of the felt need and the efforts of nurses themselves. The first step is usually taken when a nurse is selected for further training in a new field or a clinical specialty and sent away to a centre where the specific interest concerned is well established. She later returns to give service and to teach others what she has learned. An alternative to this plan is to import an expert to initiate the teaching program. By either of these methods a small group is prepared to render better service in a given field. Many of these ventures have been in such clinical specialties as pediatrics, obstetrics, or psychiatry, and are sometimes called "added experience courses." There is a growing tendency to supplement such programs by including some

classes in the scientific background of the service and also in the general principles of teaching and supervision which may be applied in that specialty. The facilities of colleges or universities are often used in this connection and this association tends to raise standards by ensuring more uniform entrance requirements and by strengthening the clinical resources as well as the calibre of the teaching personnel.

There are others which have been designed to supplement the basic course in order to prepare a nurse for public health nursing. These are usually conducted under university auspices. Much of what is still included in programs for this group is really elementary though necessary to make up deficiencies in the basic course. The same is actually true of most of the courses in teaching, supervision and administration in varying degree. Successful practice should undoubtedly be a prerequisite for such programs. There are always two points of view on this matter, the first being that the nurse who has her postgraduate course is better prepared for the field, but the factor of getting theory before practice operates here. The second is that the nurse who has been in the service first profits so much more from her course for the obvious reason that she knows so much better what she needs and can relate theory to practice. There is always the question as to how long is long enough to work in the field before securing further preparation. This can never be settled arbitrarily in terms of years or months because of individual learning rates and because of the variance of learning opportunities in the service itself.

There is yet another type of program which is still in the developmental stage and that is the "workshop." It seems to me that this plan, which brings together for a few days or weeks a relatively small experienced group who share a common interest or common problem, comes nearer the real answer to many of the weaknesses in our present system. By bringing together those who are interested and a counsellor or leader who has proven ability in that particular subject or problem, by providing that most essential ingredient, uninterrupted time for thinking through the whole situation, and some essential tools in the form of books, reports, and other available materials, much that is of permanent educational value should ensue.

If it is true that education for individuals must be cut to individual measurements it is

equally true of nations. No one pattern for post-graduate education in nursing can be presented which will serve all countries in varying stages of growth. Miss Stewart's committee has based its report on broad general principles, the fundamentals. We must accept the fact, rather regretfully I am afraid, that each of us must take these principles and work ourselves to make the best use of them we can in the light of present and future needs, resources, and trained personnel.

What students at any level need most is not the teacher who will pour out information often resulting in what one educationist has called "a mind loaded with undigested lumps of information," but one who can inspire them, who will help them to find new knowledge, new skills, and new faith in themselves. What we need in nursing is more teachers who can restore our faith in the future of nursing, who will help us to find a new outlook and a broader vision.

Nursing Groups Other Than Registered Nurses

C. A. NOTHARD

I propose to deal with this topic mainfy in the light of conditions pertaining to the Union of South Africa. It is essential for me to briefly describe the conditions under which nurses follow their profession in our country.

In South Africa at present both registered and non-registered nurses may practise nursing and call themselves nurses. At the outset I wish to express the view that this state of affairs is in many respects most undesirable. In common with all other countries in the world, we are suffering from a severe shortage of registered nurses in the Union. While this shortage persists the practice of non-registered nurses with little or no training will have to be countenanced.

In 1944 the Nursing Act was placed on the Statute Books. This Act provided for the establishment of two independent bodies—the South African Nursing Council and the South African Nursing Association. The nursing association is charged with raising the status and promoting the interests of nurses. This statutory association replaced the now defunct South African Trained Nurses Association. By law all registered practising nurses are compelled to become members of the S.A. Nursing Association.

Prior to 1944 the powers vested in the S.A. Nursing Council were in the hands of the S.A. Medical Council. The function of the Nursing Council can be summarized as that of safeguarding the interests of the public in so far as nursing services are concerned. Notwithstanding the fact that it would, therefore, appear that the functions of this Council may be to a certain extent in conflict with those of the S.A. Nursing Association

these two bodies work in close co-operation and harmony. The reason for this happy state of affairs is that it is realized by both that in order to give the public a satisfactory nursing service it is necessary to ensure that nurses carry out their work under the best possible conditions and conform with the highest ethical standards.

The Nursing Council is enabled to safeguard the interests of the public by virtue of the fact that it is in control of the training, examination, and registration of nurses. The Council also has legal power to impose certain penalties upon any registered nurse who, after due enquiry, is found guilty of any unprofessional conduct.

The Nursing Council approves of hospitals as training schools and regularly inspects such hospitals in order to ensure that a proper standard of training is being maintained. The Council is the sole body charged with the conduct of all examinations for nurses in the Union.

Admission to the Council's registers can be obtained in one of two ways. Firstly, by completing the prescribed course of training and passing the examinations conducted by the Council. Secondly, a person who has obtained her nursing qualifications overseas may be registered in the Union of South Africa after she has satisfied the Council that the standard of training and examination for such qualifications are at least equal to that prescribed in the Union.

It may be of interest to mention at this stage that, in common with the practice in most other countries, the Nursing Council registers three classes of nurses—medical and surgical nurses, which are usually known as general nurses elsewhere, male nurses, and mental nurses. In addition thereto the Council is also in control of the training and registration of midwives and wherever I use the expression nurse it must be understood that it includes the aforementioned three classes of nurses as well as midwives.

It would be well for us to clear our minds regarding what is involved by the expression registered or registration as applied to nurses. As far as I am aware throughout the civilized countries of the world only persons duly registered as medical practitioners may carry on the practice of medicine. In very few countries is the practice of nursing limited to registered nurses. What are the advantages and disadvantages, therefore, of being a registered nurse when a non-registered person can also practice nursing with impunity?

The advantages accruing to registered nurses in the Union of South Africa are briefly the following:

- (a) The expression "registered nurse" is protected by law and no one but duly registered nurses may use it.
- (b) Experience has convinced the public that the services of a registered nurse are preferable to those of a non-registered one. A non-registered person accordingly sometimes finds it difficult to make a living.
- (c) All government hospitals in the Union, including approximately 90 per cent of the total available hospital facilities, will only employ registered nurses on their staffs.

The disadvantage of being registered, if it could be called a disadvantage, is that registered nurses have to conform with a strict ethical code whereas the actions of non-registered nurses are subject only to the civil and criminal laws of the country.

With a view to enabling the public to recognize a registered nurse as such, the S.A. Nursing Council recently introduced, under the provisions of the Nursing Act, certain distinguishing devices which may only be worn by persons duly registered with that body. Severe penalties are prescribed for the unauthorized wearing of these devices or any imitation of them by non-registered persons. The distinguishing devices take the form of colored epaulettes to which are attached the badges of the Council in silver. Every registered nurse is compelled by law to wear these epaulettes whenever she is in uniform and on duty. It is remarkable how rapidly the public has come to associate these epaulettes with fully trained nurses.

colored epaulettes are used to indicate whether the wearer is a general nurse, male nurse, mental nurse, or midwife.

Before endeavoring to describe to you how the problem of the non-registered nurse has been approached in the Union of South Africa, I wish to divert for a few moments and tell you something about the non-European or Bantu nurse in our country. So far as the Nursing Act is concerned, no discrimination whatsoever is made along the lines of color or race. European and non-European nurses are dealt with as one group. Non-European nurses receive their training under exactly the same conditions as are prescribed for Europeans. They write the same examination and are admitted to the same registers. At present the European nurses outnumber the non-European nurses in the proportion of something like 4 to 1. The population of the Union is comprised of approximately nine million non-Europeans and two and a half million Europeans, and these figures indicate that in the near future larger numbers of non-European nurses will have to be trained if the Union of South Africa is to acquire an adequate nursing service. The authorities are aware of this urgent need for more non-European nurses to be trained and active steps are being taken to remedy the defect.

Hitherto a relatively large number of non-European nurses have been trained in mission hospitals situated in the native reserves. While the training given by these mission hospitals is suitable for the type of trainee who makes application and adequate in the light of the type of practice that these nurses will be called upon to undertake, it is not up to the standard prescribed for state registration. It may not be generally realized that in South Africa we find the extremes of highly modernized communities on the one hand and primitive pastoral groups of people virtually isolated from the rest of the country on the other hand. We are thus faced with the problem of laying down a standard of registration for nurses who would meet the needs of modern specialized hospitals and also the needs of communities with little or no medical or hospital services at their disposal.

Another difficulty which arises with the training of non-European nurses is the fact that the majority of them come from native areas where they live under conditions entirely different to those pertaining to the average European home. It has often been found necessary to teach the non-European student nurse something about housekeeping

and the European ways of living before she is in a position to assimilate the contents of the course of nursing training.

As I have already indicated, in our country we are firmly convinced that the nursing services can never be regarded as satisfactory until such time as the practice of nursing is limited to registered persons with the attendant control over the exercise of their profession. The question now arises as to the manner in which we are to strive in order to attain this ideal. In South Africa a step in this direction will have been taken when, in the near future, regulations are brought into force in terms whereby the Nursing Council will control the activities of Nursing Agencies. The term "Nursing Agencies" refers to the system whereby a nurse or lay person employs a group of nurses, registered or nonregistered, on a commission basis. The public use the Nursing Agencies as a channel through which they obtain the services of nurses for attendance upon patients at their homes. The majority of non-registered nurses are in the employ of these agencies because, as I have already explained, they are not as a rule eligible for appointment to the staffs of hospitals. With the control of Nursing Agencies being vested in the Nursing Council this Council now has an indirect power of veto over the majority of non-registered nurses. If, for example, it is found that a non-registered person belonging to a nursing agency acts in a manner detrimental to the interests of the public, the Nursing Council may withdraw the right of the nursing agency to carry on its business and thus discontinue the undesirable practice on the part of the nonregistered nurse.

This indirect control of the activities of non-registered nurses through Nursing Agencies is, nevertheless, a partial solution to the problem. Last year the possibility of training a subordinate class of nurse, to be known as "nurse aides" or "nursing assistants," was considered as a solution to the problem of overcoming the shortage of registered nurses. This scheme was abandoned, however, when it was found that insufficient training facilities existed in the country to meet the demands of suitably qualified persons for the full course of training.

The question of whether all persons practising nursing, both qualified and semi- or unqualified, should be registered is continuously being presented in the Union. The pro-

posal is that the existing register, to which only fully qualified persons are admitted, should be continued and that special registers to include all those who are insufficiently trained, and are at present practising nursing, should be established. One section of the nursing profession maintained that this will be a retrograde step as they are of the opinion that it will eventually result in the standard of training of nurses being lowered to that required of the inferior group. On the other hand, it is admitted in some quarters that the registration of persons who practise nursing will make it possible for their activities to be regulated. The services of the semi-qualified nurse could thus be directed into channels for which they are best suited.

During the war women were called upon to a great extent to fill posts which normally were occupied by men, and resulted in a shortage of nurses. The reverse of this process is now taking place. As economic conditions revert to normal men are replacing women rapidly in these posts which they temporarily filled. In South Africa considerable improvements in the conditions of service and salaries for nurses have recently been effected. These factors have resulted in a vast increase in the number of recruits presenting themselves for training as nurses. Already in some provinces in the Union the number of student nurses has doubled itself over the past two years. In South Africa we may, therefore, find ourselves with a sufficient number of registered nurses to meet the needs of the community within the next five or ten years. The moment we can convince our government that a sufficient number of registered nurses is available I am confident that legislation will be passed limiting the practice of nursing to duly registered and qualified nurses. In the meantime we are aware of their shortcomings but we must be appreciative of the valuable services non-registered nurses are rendering to the community. I, nevertheless, am firmly convinced that unless the practice of nursing by non-registered nurses is regarded as purely a temporary state of affairs arising out of the present emergency every effort must be made to achieve one of two things-either they must be registered as a subordinate or inferior class of nurse or steps must be taken to ensure that an adequate number of fully qualified nurses are trained to enable the non-registered nurse to be eliminated from the practice of nursing.

A Solution Must Be Found

HARVEY AGNEW, M.D.

To WHAT EXTENT is the gravity of the situation with respect to the provision of nursing care and other service realized by hospital leaders, governments, and the public at large?

That it is a serious problem today is only too well recognized by every administrator, every director of nursing, every doctor, the nurses trying to keep services going, and by almost every patient. But most of us are still "carrying on" day by day, hoping that the situation will ultimately correct itself. We talk vaguely about the law of "supply and demand." A few years ago we said: "It's the war; wait till the war's over." Now, with the war long since over, conditions are as bad as ever; so we state with conviction that the next depression will shake everything back into a more workable society. But the next depression will probably leave us with such a jumble of half-baked labor, relief, and other laws, that confusion will be compounded, and there may well be less opportunity or incentive for sound leadership.

What we must realize is that we have with us now a situation which, if not solved, will become a MAJOR NA-

TIONAL CALAMITY.

Worse Conditions Ahead

The simple fact is that we are not heading towards any really permanent solution of nursing service, either within or without the hospital. We are patching up the old system, getting by, day by day, and hoping that someone else will hit upon a solution. Early in the war our national and military leaders warned us that conditions would become worse, much worse, before they would become better. In the long subsequent years we found their prophecy only too true.

It can be said, with equal assurance, that our nursing services in this country are going to become worse in the next few years and that improvement will only be in relation to the steps taken to meet the situation. The demand for qualified nurses is steadily increasing and will grow tremendously in the next few years. Hospitals, woefully understaffed today, must increase their facilities by many thousands of beds. before has there been such a need for expansion and never before have so many hospitals had plans ready for building when conditions and funds permit. But we must realize that if some magic wand were to bring into creation the added facilities needed, only a small proportion could be opened because of the impossibility of getting adequate personnel.

We have barely started upon our public health program. Hundreds of nurses will be needed by our municipalities and governments and, if a full-blown program of health insurance should eventuate, the numbers needed might well be numbered in Health insurance meathousands. sures, too, will probably include visiting nurse service, absorbing another large portion of each year's output. Industrial hygiene is being developed at a rapid rate and a basic feature of this program is the industrial nurse. The number of nurses left to care for the sick in hospital is bound to dwindle and, for that matter, none of the fields will be able to obtain sufficient numbers.

A regrettable feature of this situation is that none of these large present or potential employers of graduate nurses — industry, public health, D.V.A., T.C.A., etc.— train nurses themselves. It is all left to a few civilian hospitals; moreover, the hospitals, having to maintain 24-hour, 7-day service, find it hard to compete against the abbreviated schedules offered by public health and industry. Were it not for this deflection of hospital graduates into fields, non-existent a few decades ago, there would be no shortage of nurses in hospitals Many people are of the opinion that nurses on graduation

should be required to serve six to twelve months at the prevailing salaries in some hospital before going elsewhere.

OF CONCERN TO ALL

The time has come when we must face the situation squarely. Unless a far-reaching program, designed to correct these difficulties, is put into operation without delay, our entire program of augmented health care will need to be abandoned. Without trained people to provide nursing and other care, it will be quite impossible to carry out any national or provincial health program. Should an epidemic on a national scale occur the result would indeed, be calamitous. active steps to forestall this situation must be taken NOW.

This makes the situation of direct and immediate concern to our public health authorities—municipal, provincial, and federal; to the medical profession; to industry; to compensation boards and all other health agencies and boards; to the life insurance field; and to the general public, whose own health and welfare are at stake. The main responsibility for finding a solution rests not so much with the nurses and the hospitals as with the governments and other consumers of nurse services. It is obvious that the situation is so serious that nothing short of a thorough study of the subject from every angle will suffice. Moreover, the solution, or solutions, must be based on the long range view; every effort must be made to anticipate the picture twenty-five years hence and to evolve an approach with that in mind.

The Joint Committee, representing the Canadian Nurses' Association, the Canadian Hospital Council, the Canadian Medical Association, the Department of Health and Welfare, and the Department of Veterans Affairs, has begun to realize the enormity of its undertaking. What began as a simple study of present needs and their remedy has become one which must become of first magnitude if it is to get to the bottom of the difficulty and find adequate solutions.

It is going to require a good deal of outside assistance.

Comprehensive Study Needed It is apparent that the study must encompass several major undertak-

1. There must be a comprehensive factual survey of present conditions. How serious is the shortage of nurses and subsidiary workers? What are present salary and working conditions in hospitals? How do they compare with those of other groups? What is the state of student enrolment? What percentage of graduates stay in institutional work? (This phase of the study will require competent direction and much field assistance.)

2. Is our system of providing nursservice in hospitals the most efficient and economical one? Are we wasting the time of trained personnel? To what extent can employment of the subsidiary worker solve the difficulty? What controls are necessary? Has the time come when the traditional field of the graduate nurse should be reanalyzed and new allocations of duties set up as between the nurse, the physician, the interne, the ward assistant or practical nurse, the technician, the ward secretary, the nurse clinical assistant, and the dietary and other staffs?

3. Are we wasting nurse-power in other fields? Could some of the present duties of the public health nurses be assumed by others? Is the industrial nurse devoting all her time to strictly nursing care duties? What about T.C.A. stewardesses? How many are receptionists in doctors' offices, or are demonstrating food, clothing, and

appliances, etc?

4. What is the cost of operating a school for nurses? Does the hospital gain or lose by operating a school?

5. Should our system of nurse education be revised? Is the time-honored system still the best or should it be revamped to conform to present-day educational principles and methods adopted in the other fields of education? Should the course be freed of non-nursing tasks? Could it be reduced in length without deleterious

effect? To what extent could instruction be improved by centralization? Should school and hospital finances be separated (as in the proposed four-year experiment)? What effect would these changes have upon the financing of hospital operation? Is it advisable to operate a school for nurses and a school for nurse assistants, or practical nurses, in the same institution? Is there merit in the suggestion of a two-year course in nursing for general duty and a longer course for administrative or special work?

6. What are the trends for the future? To what extent will the growth of health insurance increase the demand for nurses? What will be the position of hospitals in the health scheme of the future? How will they be financed? What must be our annual output of nurses and trained subsidiary workers twenty-five years hence? Will it be necessary for hospitals to revise, perhaps downwards, their conception of standards in nursing care? If hospitals must conform to the spreading pattern of labor today to do less and less for more and more, how will the greatly-increased cost of hospital care be passed on to the public?

STUDY MUST BE AUTHORITATIVE
Unless the study to be made
answers these and many other questions it will fall short of its objective

and a lasting solution will not be found. Moreover, the study must be sufficiently authoritative that it will command the attention and acceptance, no matter how much it hurts, of the hospitals, the nursing and medical professions, the governments, and the general public.

If the hospitals have been remiss the sooner they realize their short-comings the better; if a radically new approach to nurse education is needed, present studies in that direction should be intensified; if nursing service duties should be reallocated, the professions concerned should establish new boundaries; if added public assistance through government channels is essential for nurse education or hospital operation recommendations to that effect from such a study would bear much weight with governments.

A study of this scope will require some financing, for there would be needed a carefully-chosen director of study, a statistician, a staff, probably consultants in those fields in which the director is not an authority. Much of the work could be done on a provincial basis, but the initial planning, the co-ordinating, and the summing up would need to be done by a national group. This is a project which needs further attention without delay by our national hospital, nurse, and medical organizations, their provincial counterparts, the federal and the various provincial governments.

Aluminum Utensil Dangers False

A large-scale sales promotion campaign for steel cooking utensils is being carried on, which is based on creating among housewives a fear of the health hazards involved in the use of aluminum cooking equipment.

Although it is not the purpose of this note to take sides for or against either type of cooking ware, it seems important to point out that a review of the literature on the subject has failed to disclose any toxicity or danger involved in the use of aluminum utensils for cooking.

Torald Sollman, M.D., in his Manual of Pharmacology, points out:

"The harmlessness of aluminum com-

pounds on oral administration, even when prolonged, (aside from local actions if concentrated solutions are swallowed, and the phosphate disturbance, if very large doses are given), is clearly established by both animal experiments and by clinical experience."..." This has been the conclusion of various government boards after prolonged and exhaustive experiments on men and animals..."

This view is supported by many others and confirmed by the obviously favourable experience of thousands of people in the use of aluminum.

-California's Health

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Rapport du Congrès d'Atlantic City 1947

SOEUR ALLARD

L'HISTOIRE DU CONSEIL INTERNATIONAL DES INFIRMIERES

CET ORGANISME est, une sédération des associations des gardes-malades enregistrées de tous les pays du monde. Son but est de travailler à améliorer le service des soins aux malades, de promouvoir l'avancement de la science médicale en ce qui regarde la santé publique et d'assurer les intérêts de la profession d'infirmière. Sa fondation remonte à l'année 1899. Les pionnières du mouvement furent entr'autres Mme Fenwick, d'Angleterre, décédée en mars dernier. Mademoiselle Dock des Etats-Unis, encore vivante, Mademoiselle Snively du Canada, Mademoiselle Neill de Nouvelle Zélande, Mme Norrie du Danemark, Mademoiselle Farquarson d'Australie. Toutes ces femmes qui tenaient une place importante dans leur association nationale, comprirent qu'elles étaient aussi citoyennes du monde entier. Elles réalisèrent qu'à côté de leurs devoirs professionnels existait la responsabilité de leur devoir social vis à vis l'humanité et que le moyen le plus efficace d'y travailler était de s'unir. En 1925, 19 pays adhéraient à ce mouvement. En 1947, il y avait des représentantes officielles de 35 pays, à part des quelques autres pays non encore adhérents. Voici ces pays: L'Angleterre, les Etats-Unis, Canada, Danemark, Finlande, les Pays Bas, les Indes, Nouvelle Zélande, Belgique, Chine, Norvège, l'Afrique du Sud, France, l'Irlande, la Pologne, le Brézil, les Philippines, Grèce, la Suèle, Czéchoslavie, la

Hongrie, l'Australie, la Roumanie, la Suisse, le Chili, la Palestine, l'Italie, le Mexique, l'Autriche, l'Espagne, le Venezuela, Yugoslavie, l'Ecosse. En organisation, l'Egypte, Luxembourg, Siam, Syrie, Turquie.

LE CONGRES

La convention de 1947 ressemblait à toutes les conventions par l'horaire des séances, les présentations, les discours, les discussions et les réso-Cependant, Atlantic City est vraiment un endroit exceptionnel pour une réunion de ce genre. L'auditorium est immense, le plus grand du monde nous a-t-on dit, et les autres salles de réunion sont vastes, bien aérées et faciles d'accès. A part cette facilité de local, il y a la voix chantante de l'Océan et l'agréable panorama des horizons sans fins. Comme le faisait remarquer Son Honneur le Maire Altman à l'ouverture du Congrès, la mer est attirante, on vient ici la voir dans sa majesté, mais ajouta-t-il, les gens aussi sont intéressants, vous en trouverez la preuve en constatant que la presque totalité des bancs de la grande promenade sont tournés non vers la mer, mais vers la cité. On vient ici, ajouta-t-il, voir la mer, mais aussi les gens et les choses qui sont parfois aussi captivants.

Les séances du Congrès furent nombreuses et bien suivies. Les assemblées générales furent présidées par Mademoiselle Effie J. Taylor, la présidente active du Conseil international depuis 1937. Les sessions spéciales furent présidées par les dirigeants des différents pays. Scule la langue

SEPTI MBER, 1947

anglaise fut parlée durant le Congrès, contrairement aux conventions antérieures alors que le français et une troisième langue étaient de rigueur. Pour cette raison, l'intérêt général semblait moins grand parmi l'assistance alors qu'un certain nombre d'infirmières de l'Amérique du Sud et de certains pays d'Europe, ne pouvait pas suivre les discours prononcés en Elles désiraient un interprète pour donner un résumé sommaire de ce qui se disait. Les interprètes officielles sont, nous a-t-on dit, toutes à l'emploi des grandes organisations mondiales, telles que ICAO, ONESCO, l'ONU, etc. Il fut impossible de se procurer leurs services, d'autant plus que jusqu'à la dernière minute on se demandait si vraiment le Congrès pouvait avoir lieu. Il a fallu surmonter plusieurs difficultés, d'ordre économique surtout, et il n'était pas facile de trouver des moyens de transports pour les infirmières de l'Europe et les autres pays éloignés et dévastés par la guerre. Les organisatrices durent cependant être fières du succès, car plus de 6,000 infirmières s'inscrivirent.

LE PROGRAMME

Les sujets discutés dans les assemblées générales étaient tous d'intérêt mondial et portèrent sur les problèmes sociaux particuliers aux temps pré-Par exemple, on parla de la famine des pays dévastés par la guerre. Le tiers de la population du monde est soumis à un jeûne forcé et soixante millions d'enfants et d'adolescents meurent de faim. Cette déclaration fut faite au Congrès par un norvégien, Monsieur Ording, consultant au Bureau des affaires économiques des nations unies. Il fit un appel vibrant en faveur du don d'une journée de salaire par tous les travailleurs, et d'un don plus substantiel de la classe plus fortunée pour aider à combattre la misère et la famine qui sont vraiment les deux grands obstacles à l'établissement de la paix.

Monsieur Snyder, directeur de la commission internationale de reconstruction, parla en faveur de l'éducation, comme d'une force puissante pouvant aider à rétablir la paix. Une bonne infirmière est aussi une bonne éducatrice. La santé et l'éducation doivent marcher la main dans la main. Il demanda aux infirmières de ne pas faire bande à part, de ne pas s'isoler mais de prendre une part active à l'effort que les peuples font en ce moment pour une compréhension plus intelligente des besoins et des ressources des différents pays.

Les séances particulières ou leurs sections étudièrent tour à tour les différents problèmes que l'on croirait parfois particuliers à notre pays, mais ces difficultés existent en réalité dans tous les pays du monde. On parla du manque de gardes-malades dans les hôpitaux. On fit remarquer que la spécialisation de l'infirmière comme travailleuse sociale dans l'usine, l'industrie et les autres services, avait constitué au début un progrès, mais que la spécialisation intense des dernières années devenait une menace. Si le tiers des infirmières se dirige dans des positions à l'extérieur des hôpitaux, c'est un bien, mais si les deuxtiers désertent l'hôpital c'est un mal et c'est ce dont nous souffrons actuellement. On conseilla d'améliorer les conditions de travail de l'infirmière dans les hôpitaux, meilleur salaire, heures moins longues, pension de retraite, etc.

On insista beaucoup sur la nécescité de ne pas déserter les hôpitaux spécialisés; les tuberculeux, les aliénés, les invalides ont droit à nos soins tout comme les malades des hôpitaux généraux

De la pénurie d'infirmières est née la classe des auxiliaires, aides-malades, practical nurse, sous graduée, etc., de quelque nom qu'on l'appelle. Cette catégorie d'aides semble nécessaire voire indispensable. Mais l'avis unanime de tous les pays semble reconnaître la nécessité pour ces aides d'avoir un entraînement approprié, une formation spéciale, et un règlement pour les régir, une loi de contrôle pour le port de l'uniforme, les conditions de salaire et de travail.

Les différents pays présentèrent des rapports intéressants et variés. Par exemple, le Conseil du Nursing d'Angleterre terminait son rapport par un extrait du Rapport annuel du Collège Royal, à la fin de la guerre: "Les nations ont à envisager des problèmes presqu'insolubles. Mais les nations sont composées d'individus et si chacun remplit son devoir avec fidélité et courage, on reconstruira un monde meilleur, sur une base solide qui assurera sa survivance."

Aux Etats-Unis, il est à remarquer qu'il existe une association fédérale de gardes-malades et que chaque état possède sa loi particulière. Mais toutes ces organisations ont le même but. Outre la surveillance des écoles et des études, on accorde la licence aux candidates qui le méritent et on protège le public contre les incompétentes.

Le bureau de l'association nationale aux Etats-Unis a eu beaucoup de travail pour réaliser la classification du groupe des auxiliaires (cadets) entraînées pendant la guerre, pour évaluer les qualifications de celles qui désiraient continuer leur service aux malades après avoir quitté le service militaire. Un comité étudie présentement cette question des (practical nurses) qui amènera sans doute la législation d'une licence pour tous ceux qui soignent les malades à quelque titre que ce soit.

Au Danemark, les gardes-malades du service privé sont rémunérées à l'heure depuis octobre 1946. On prévoit le même barème de salaire pour celles qui font du service à Le conseil national des domicile. gardes-malades au Danemark a établi depuis 1942 un fonds de l'assurance chômage. Ce plan est obligatoire pour toutes les gardes-malades en service actif et oblige aussi les élèves en 3e année d'étude. Cette assurance chômage fonctionne indépendamment de l'Etat avec un bureau dans chaque localité. Une fois établie cette organisation reçut l'approbation civile et légale, et le gouvernement contribue maintenant sa part proportionnée au nombre des membres. L'association des gardes-malades du Danemark possède aussi son fonds de pension, son assurance maladie, de vieillesse et de retraite. Elle possède

aussi sa maison d'infirmières, sa maison de convalescence, sa maison de repos et de vacance. Ces gardes ont été moins affectées par la guerre, aussi sont-elles prêtes à envisager la solution des différents problèmes qui se posent aujourd'hui.

Les gardes-malades de Finlande eurent beaucoup à souffrir de la guerre, 14 furent tuées en service, 12 moururent des suites de blessures, elles nous dirent cependant que le spin des malades, et l'amélioration de la santé publique ne furent pas négligés malgré les difficultés qu'il a fallu surmonter. Elles restèrent vaillantes en face de ces épreuves et sont aujourd'hui toutes prêtes à travailler à la reconstruction qui s'impose dans tous les domaines.

En Chine, on souffre beaucoup et on manque de tout surtout d'argent et de matériel. La lingerie de certains hôpitaux manque totalement. On doit reconstruire plusieurs hôpitaux détruits par les bombardements et travailler à réorganiser les écoles d'infirmières. La pénurie d'infirmières se fait sentir dans tous les domaines. Actuellement les infirmières chinoises restent vaillantes en dépit des difficultés, elles lancent une campagne de souscription en vue de reprendre le travail de leur association.

En France comme dans tous les autres pays du monde on manque de gardes-malades. Le Ministre de la Santé favorise l'ouverture et le développement des écoles. Malheureusement le manque de personnel enseignant empêche de réaliser de suite tous les progrès en vue.

En Afrique du Sud, dans les Philippines, en Czéchoslavie et ailleurs on se consacre à un travail intense de reconstruction, et de la formation de nouveaux sujets. Dans les Philippines par exemple on a 350 applications d'entrée dans les écoles alors qu'il qu'il n'y a de place que pour 28.

La Suède à l'exemple de la Norvège possède une organisation sociale avancée en fait d'assurance, fonds de pension, maison de repos, etc.

Malgré les difficultés de la guerre, il semble bien qu'on a essayé dans tous les pays à maintenir l'idéal élevé de la profession et la qualité des soins aux malades. On cherche aussi activement à entretenir la coopération sur une base internationale.

La plupart des pays parlèrent des restrictions sur les habits, la nourriture, des rigueurs du froid, des logements insalubres, etc. Dans quelques-uns, depuis des années on n'a pas parlé d'autres problèmes que ceux de la nourriture et du chauffage, tant la misère y est grande.

On remercie les Etats-Unis et le Canada de l'aide efficace apporté pour aider à solutionner ces grands problèmes de ravitaillement, etc. Voici quelques-uns des principaux points mis à l'étude au cours de ce congrès international. Il est évident que l'on ne peut pas rapporter en très peu de temps tout ce qui s'est passé dans une semaine.

Le prochain congrès aura probablement lieu en 1949, à Stockholm, en Suède. 1949 marquera le jubilé d'or de l'Organisation internationale.

Les officières élues furent une suédoise Mlle Hojer, présidente, les autres membres du conseil furent: une anglaise, une américaine, une canadienne et une infirmière de la Nouvelle Zélande.

Why Immunize?

Canada's fifth National Immunization Week will be observed this year during the week of October 5-11. Sponsored by the Health League of Canada in co-operation with the nation's health departments, the purpose of setting aside a special "week" is to focus the attention of workers and parents alike on their obligation to safeguard the children, so far as is possible in the present state of medical knowledge, from wholly unnecessary attacks of preventable communicable diseases.

Though there has been a sharp drop in the past decade in the incidence of certain of these diseases, notably diphtheria, whooping cough, smallpox, and scarlet fever, there are still enough cases occurring every year to make us, the nurses of Canada, pause and wonder if perchance we have failed somewhere. It is probable that some time in the course of every year, some nurse, either in her professional capacity or through friendly contacts, talks to the mothers of the greater part of the children in Canada. These formal or informal chats provide golden opportunities for the nurse to make inquiries and give information regarding the protection that has been or may be given the children. Yet, the very fact that in the first six months of

1946 there were 2,535 cases of diphtheria in . Canada, from which 111 persons died, means that many parents were not informed or were not persuaded of the efficacy of diphtheria toxoid to prevent this disease. Similar statistics could be quoted for the other preventable diseases mentioned.

The problem is not peculiar to any one community or province. Having a special week to make every person more alert to the problem will not solve it. But, if every nurse—students and graduates, active or retired—made it her personal responsibility to focus the attention of all of the parents with whom she comes in contact on the possibility and feasibility of reducing incidence and possible death rates by immunization, there would be startling results.

This is not a weighty extra that might be likened to the proverbial straw. It is an easy adjunct which each of us can perform. Start during this National Immunization Week. Every child of your friends, acquaintances, and mere incidental contacts protected! What a record that would be! If your present information about immunization is scanty, write to the Health League of Canada, 111 Avenue Road, Toronto 5, for literature. Help to wipe out these killers!

Bone Banks

Add "bone banks" to the health plans of the future. The Orthopedic Hospital in New York has established a "bone bank," the forerunner of similar banks which may some day be established in all large cities. Bone banks will have "deposits" of preserved pieces of human bone ready at all times for use by surgeons in repairing bone defects resulting from disease or injury. The pieces of bone are preserved by deep-freezing.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Group Study at the Veterans' Village

ISOBEL BLACK, B.Sc.

FREQUENTLY resources to meet our needs can be found in commonplace situations close at hand! This was strikingly demonstrated for us at the University of Manitoba School of Nursing last winter as we sought opportunities for supervised student experience in leadership of lay study groups. We were also impressed at the way in which our own needs were met in the very process of giving a service required of us. In this situation our need for experience in group work for our public health nursing students coincided with the need for a health education program for the wives of veteran students.

These young women live with their families in the seventy-two temporary huts provided on the university site for married veteran students. There are many small children in these homes, and quite a number of prenatals. The need for a health service for these families was recognized and was provided by the co-operative effort of several organizations. The Nursing Division of the Manitoba Department of Health and Public Welfare conducted child health conferences and immunization clinics. The Manitoba Red Cross Society organized a mothers' study group and asked the Public Health Nursing Division of the University School of Nursing to plan the content of study with the mothers and to lead the discussions. By the time this project was undertaken the students were well prepared for this activity, having

completed a unit of study on group work in public health nursing and observed study groups in action. They had completed their course on maternal hygiene and were studying child development, so were equipped with content for the two areas of greatest relevancy to the mothers as determined by a questionnaire. As a result of the interest expressed by the mothers we planned two groups—one for prenatal clients and one to study the preschool child.

The public health nursing students met several times as a group to plan the project. As time was limited we decided on five meetings with each group as an introductory venture.



Entrance to Arts Bldg., University of Manitoba

The study of the preschool child followed the prenatal group meetings, so members from the latter could join in the child study if they desired to do so. The class worked out their objectives together and then planned suggested topics for discussion to be presented to each group at the first meeting. These suggestions were left in a flexible form to allow for changes in order to meet new interests expressed by the mothers. We planned a library service for the members of the group. For this we obtained books from the library of the Department of Health and Public Welfare and a few from our own shelves at the university. We loaned these to the mothers, using a simple card system in order to keep track of the books. In addition, we used selected issues of Parents' Magazine and Hygeia and, of course, free pamphlets from the Department of Health and Public Welfare. We obtained movies and film strips from the National Film Board and the Health Education Division of the Health Department. The students worked in groups of two or three in planning for each meeting. One of these led the discussion the night of the meeting and the other one or two observed. There was an average attendance of ten throughout the study.



Veterans' homes

Following is a statement of the objectives and a brief outline of the content of each of these groups as prepared by the students.

PRENATAL GROUP

Objectives:

1. To develop a knowledge of some of the changes which take place during pregnancy and to encourage hygienic living for the pregnant woman and her whole family.

2. To assist the mother in promoting a positive attitude on the part of the whole

family towards the new baby.

3. To develop skills in caring for the baby.

At each of these meetings we had a bathroom scale so the mothers could weigh themselves, keeping a record of their gain. We also had equipment for demonstration of the baby's bath, a layette, copies of the "Canadian Mother and Child" and the books and pamphlet material already referred to. At the first meeting the nurse demonstrated the baby's bath. After that a different mother tried it at each meeting.

First meeting: Presentation of proposed topics and suggestions from members. Demonstration of a baby's bath, dressing, lifting and carrying the baby, the baby's emotional response to the way he is handled. The baby's toilet tray. Patterns for the layette.

Second meeting: What a healthy baby is like at birth. The kind of home a baby has the right to enter. What the new baby means to the various members of the family and how all members are prepared to accept him. The part played by all members of the family in the baby's development.

General hygiene of pregnancy and how it can be included in general hygienic living for the whole family.

Third meeting: Physical and emotional considerations in feeding the baby. Breast feeding. Care of the breasts. General principles of formula preparation.

Film strip-"Nine to Get Ready."

Fourth meeting: The baby's day. Studying the baby's needs as a basis for determining a flexible routine. Significance of the baby's cry. Music and play during the first year.

Film-"Clocking a Champion."

Fifth meeting: How the baby is born. What to expect of the hospital. What to prepare to take to the hospital.

THE PRESCHOOL CHILD Objectives:

- To develop a knowledge of normal growth and development during the preschool years.
- 2. To prepare parents to meet and overcome some of the everyday problems of training for habits and attitudes.
- 3. To develop an appreciation of measures for prevention of disease and promotion of health.
- To help the group acquire a knowledge of community resources and to develop the ability to work co-operatively to meet mutual needs.

First meeting: Presentation of proposed topics and discussion of suggestions from members. Overview—general development of the preschool child; the maturation process.

Second meeting: Training for desirable habits—eating, sleeping, elimination, independence, self-help, socialization.

Third meeting: Some problems parents encounter—thumb-sucking, enuresis, temper, problems related to truthfulness, honesty, and courtesy.

Film-"Your Children and You."

Fourth meeting: Play-its place in the child's life.

Demonstration of simple play material. (These materials were loaned by the director of the Home Management House of the Home

Economics Department of the university.)

Fifth meeting: Preparing the child for school, physical examination, correction of defects, being sure he can participate in the group and is independent of his mother.

Both the students and the group members found this group study project helpful and interesting. students felt much more confident in their ability to organize and leadership to community groups. The mothers enjoyed it and are planning to go on with further study next year. We have received suggestions from fathers for a group for them. They showed definite signs of not wanting to be left out of this preparation for better family life. We, of the faculty, felt the project was of such value, educationally, that we wonder now if we could go further on this as a practice field, perhaps by giving a generalized public health nursing service to the group as a field work project carried throughout the year of study. The situation is ideal: young, interested, eager families right on our campus. This opportunity is of a temporary nature, but it has inspired us. Who knows what we may find to take its place if we but look with discernment "right around home"?

In Memoriam

Jean Isabel Bell, R.R.C., who served with distinction with the C.A.M.C. in World War I, died in Ottawa in her sixty-ninth year. Miss Bell enlisted in 1914 and saw active service in France. At Lemnos, in the Aegean Sea, she assisted in the establishment of a clearing station serving evacuees in the Dardanelles area. For the last two years of the war, she was posted to a hospital ship. Before enlisting, Miss Bell had nursed at Haileybury and Cobalt, Ont. On her return from overseas, she nursed at various hospitals in the United States. She was, on the staff at Ste. Anne de Bellevue for a time. Miss Bell retired from active nursing in 1938.

Margaret Campbell McGilvray, a graduate of the Winnipeg General Hospital, died in Winnipeg on May 29, 1947. Miss McGilvray served overseas from 1914 to 1919 during the first World War. On her return to

Canada she was appointed night supervisor at the Winnipeg General Hospital, which post she occupied until her retirement in 1938.

Rev. Sister François Jouin of St. Therese Hospital, Tisdale, Sask., died recently.

Katherine S. Sharp, formerly of Napanee, Ont., died in Toronto on May 26, 1947, in her 91st year. As a young woman Miss Sharp trained at the Boston General Hospital. She engaged in private duty nursing in the United States for some years before returning to Canada to take up residence.

Hannah Gertrude Turner, aged sixtynine years, died suddenly at Haney, B.C. Miss Turner had nursed at Nakusp and Alert Bay. She retired four years ago.

Helen Mary Walsh, who had practised her profession in Fredericton, N.B., for many years, died there recently.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Leisure Years — Pleasure Years

K. ETHEL GRAY, R.N.

LOOK! A rainbow! Those glorious colorings arched in the sky bring joy and inspiration but, in addition, renew one's faith, hope and courage. The pot of gold at the end of the rainbow may be a dream but could be a reality of social security in relation to our income for the later years of our life. Superannuation, annuity, pension or income endowment are terms used to describe the monthly cheque when working days are over. The rainbow symbolizes our journey through life with the rise to the tip of the arch representing our increased productivity and the decline, our lessening vitality for remunerative work. The annual vacation is planned with pleasure and anticipation. It is only in recent years that more people are planning for that longer vacation through annuity or superannuation.

Nurses have been asking: Why not pension plans through our association? Membership in an association does not constitute employeremployee relationship which is essential for a contributory superannuation program. Therefore, the C.N.A. has been unjustly criticized. Excellent annuity contracts are available through the life assurance companies. Through fear or lack of knowledge, or possibly low salaries, too many nurses in the past have hesitated to utilize these golden opportunities. However, some nurses have had a planned program and are now enjoying security for life through the monthly cheque from the life assurance company. Now, other oppor-

tunities are unfolding.
But first, why work? Food, clothing, and shelter are basic necessities. All work and no play brings a price, therefore provision must be made for recreation and cultural pursuits in order to keep medical and, hospital costs at a low level. And, thirdly, before we have indulged in too many luxuries, we need to save and employ a portion of our earnings for our older self. The employment of our money will guarantee a life income or whatever term you choose to use. Part of our salary at work today will provide for our tomorrow—the pot of gold at the end of the rainbow will be a reality.

In British Columbia, as elsewhere, nurses are engaged in many fields of activity. There has been an awareness of the need for future income, possibly accelerated by the publicity given to old age pensioners. At seventy, a nurse may apply for this pension of \$35 per month. A means test is required before pension is granted. Afer receiving this grant, periodic investigation is required by the government. Overseas nurse veterans are eligible for the War Veterans Allowance which is similar to an old age pension but at an earlier age, providing she meets the means test. The small disability pension is deducted from the \$30.41 maximum allowance. The recipient receives a cheque for each amount.

Nurses in Department of Veterans

Vol. 43, No. 9

Affairs hospitals who are on the permanent civil service list are eligible for superannuation. The basis for this retirement cheque is the number of years employed, divided by fifty, multiplied by the average salary for the last ten years. For nurses employed as temporary Dominion civil servants, there is a retirement allowance deduction, refundable with interest upon separation from service.

The Victorian Order of Nurses for Canada has a superannuation program which came into effect October Much credit is due John 1, 1945. Wilson McConnell as president of the national V.O.N. Board. Through his efforts, the Princess Alice Million Dollar Fund was collected and established as a nucleus through the Dominion Government annuity branch. This fund contributes 3 per cent, the local board of the Victorian Order of Nurses contributes 3 per cent, and the employee 4 per cent towards the retirement annuity at the age of sixty. Optional types of annuity at maturity are available. One year's service is required of the nurse before this contract is in force. If the nurse leaves the Order, her credits are held until she is sixty. She may continue her contribution but there is no further deposit from her former employer.

In 1938, nurses employed in the Tuberculosis Division of the Provincial Department of Health in British Columbia began a superannuation program. In 1945, the Provincial Civil Service Superannuation Act was passed, consolidating various groups. The public health nurses are classified as Civil Servants, Class "B", after six months' employment. An employer-employee contribution of dollar for dollar is the basis used, with compulsory retirement at sixty, or permissive retirement at fifty-five if there has been fifteen years of service. The employee may contribute up to 10 per cent more, voluntarily. If separated from service, the nurse receives a refund of the amount of credit, plus interest. If she returns to service within three years, her superannuation may be reinstated. Provision for disability pension of \$30 minimum, after ten years contributory service, is included in the Act. The death benefit before superannuation is return of credit, plus 3 per cent interest.

707

Also in 1945, the Municipal Superannuation Act came into effect in British Columbia. Government-aided hospitals can participate. The Vancouver General Hospital and Royal Jubilee Hospital, Victoria, each have had a plan in operation since 1946. The employer contributes 7 per cent of salary and the employee, the nurse, about 4 per cent. The employee may increase her contribution. A minimum of \$30 after twenty years' service is provided. One year of service is required before the individual may participate. The credit, plus interest, is refundable when the employee separates from the service. At Royal Jubilee Hospital, the nurses are reported as pleased with this plan of retirement. It is a minimum plan requiring individual assurance for a satisfactory income.

Nurses are a migratory group. Younger nurses seem reluctant to take advantage of available plans for they want to go places and see things. Old age seems far off. Furthermore, marriage may solve many financial problems!

Six years ago, the writer introduced a salary savings plan at St. Joseph's Hospital, Victoria. This plan operates through the Sun Life Assurance Company of Canada. Each employee has the opportunity to authorize a monthly deduction from the total The hospital accountant cheque. totals the deductions and mails one cheque to the company. There is no employer responsibility except in so far as encouragement is given the employees to participate. Each employee has an individual contract. Income endowment assurance or annuities with or without protection provide a tailor-made contract. the nurse leaves St. Joseph's, she may continue her premiums on a quarterly or annual basis. Those who have had the benefit of this service are satisfied. "I could not have started if we

had not this plan and I have not missed the amount I authorized."

The possession of a guaranteed annuity for life adds much to one's peace of mind and security. No investment worries and a monthly cheque is conducive to longevity as reflected in annuity experience. One annuitant, a clergyman, celebrated his 105th birthday last October. In his own handwriting he says, "You have comforted, supported and helped me during the last twenty-four years—some of them most trying and

oppressive. . ." And what of those nurses who have not the above opportunities? A comparison of federal versus private life assurance company annuities was published in the Financial Post. The flexibility of options with the private company is an advantage. The cash option in lieu of annuity at maturity is not permissible with Canadian Government annuities but if the annuitant were ill at the retiring age, the cash option is available with the private life assurance company. While loans are not encouraged, situations may arise requiring ready cash and a private policy will meet this need, but the government annuity has neither cash nor loan values. An income endowment assurance contract is an excellent investment if you can get it. This contract will increase your cash at retirement.

In January, 1947, the Registered Nurses' Association of British Columbia arranged a pension plan with the Canadian Government Annuity Branch for its employees, effective after one year of service. Participation is voluntary. There is a choice of retirement age. The employer contributes 5 per cent and the employee a minimum of 5 per cent which may be increased to 10 per cent. Before retirement, the death benefit is the refund of contribution, plus interest at 4 per cent.

From the foregoing analysis, one fact stands clearly—a portion or percentage of the salary of the younger nurse of today must provide the income for the time when she will be the older nurse of tomorrow. Some employers, especially governmental authorities, have a deduction from present salary for retirement as a condition of employment. Other employees have to make a voluntary decision. Nurses in private duty or other fields may secure an excellent annuity program through the Dominion Government or through the life assurance company of their choice. Whatever the plan which fits the individual need, she and she alone must decide her goal and how she is going to reach that goal. And what is the goal? The pot of gold at the end of the rainbow—a cheque every month for as long as she lives, with another cheque to meet, with ready cash, those last expenses. With such a planned program, freedom from want and freedom from fear are a reality.

Medical-Social Assistance to Nurse War Victims

The Secretariat of the League of Red Cross Societies has undertaken to provide medical assistance to nurse war victims since the beginning of the year 1945.

At that time, the Canadian Red Cross donated \$10,000 (38647.35 Swiss Frs) along with the Brazilian, British, India, New Zealand, and Irish Red Cross. The International Council of Nurses also donated 15,268.20 Swiss Frs and the Trained Nurses' Association of India 1219.55 Swiss Frs. With some miscellaneous contributions, a total fund of 126,225.20 Swiss Frs was accrued.

To date, thirty-nine nurses belonging to eight different nationalities have gone to Switzerland for periods of cure and convalescence varying from a few days to a few months. Three Austrian nurses are still under medical care in Switzerland; one Italian nurse is pursuing her treatment at the expense of the Italian Red Cross. Two German nurses are expected shortly and the Czechoslovakian Red Cross has been invited to designate a candidate from their country to benefit from the scheme. Several Greek and Polish nurses are being treated in their own countries...

Notes from National Office

British Empire Nurses War Memorial Fund

The representative of the Canadian nurses, Miss M. Doris Anderson, was presented to Her Majesty, the Queen, at the garden party in connection with the British Empire Nurses War Memorial Fund which was held at St. James' Palace, London, on July 8.

Miss Anderson had been chosen, at the request of the Fund, by the Canadian Nurses' Association, and the Queen talked to her for several minutes about Canada and Canadian affairs.

Representatives of twenty countries of the British Commonwealth and Empire formed a semi-circle round the Queen as cheques were presented to Her Majesty on behalf of the Fund. The first of these cheques represented the total, £37,400, already subscribed

to the Fund by the nurses of the British Commonwealth and Empire (including gifts from the Dominion of Canada, on whose behalf the Canadian Nurses' Association sent a donation of £25). The last cheque presented was one of £1,500, a first donation from the people of Bermuda.

The British Empire Nurses War Memorial Fund was founded in January, 1946, and launched through the pages of the *Nursing Mirror* which is paying all of the administrative expenses. In the eighteen months of its existence it has raised nearly £47,000. The purpose of the Fund is to provide a worthy war memorial to the nurses and midwives of the British Commonwealth and Empire.

This memorial is twofold: the first part is the furnishing of a chapel in Westminster Abbey, which is to cost £5,000. This portion was over-



Variant. Man a Pis .

subscribed within the first three months. For this purpose the Dean and Chapter have allocated the Upper Islip Chapel which, when it is dedicated as a nurses' chapel, will be brought back into use for the first time since the Reformation. It will house the Roll of Honor containing the names of those nurses who died during the war period of 1939-1945, including the names of Canadian nurses.

The second purpose of the Fund is to provide post-graduate travelling scholarships for nurses and midwives of all parts of the British Empire and Commonwealth, and it is hoped that a sum of not less than £200,000 will be raised for this purpose. To endow each scholarship in perpetuity will cost about £16,000, yielding an income of £350—£375 a year.

Two travelling scholarships have

already been given to the Fund. These were presented to Her Majesty at the garden party. The first came from the Royal College of Physicians of England, and was presented by Lord Moran, president of the College, who is Chairman of Appeals for the Fund. The second is the gift of Viscountess Mountbatten of Burma. C.I., D.C.V.O., C.B.E., Vice-Reine of India, who is vice-president of the Fund. Both these scholarships are for seven years only, given under the seven-year covenant scheme.

It is hoped that many Canadian nurses will be among the future holders of war memorial scholarships. Details of qualification are naturally not yet decided upon, but scholarships are intended to be for nurses and midwives who are qualified according to the requirements of their own country, state, or territory.

With UNRRA in Germany

Lyle M. Creelman

REPATRIATION OF DPs

• The general objective of the whole program of UNRRA in Germany was the repatriation of displaced persons and, although resettlement for those who were unwilling to be repatriated became necessary, an extensive and successful drive was made early in 1946 to send home as many DPs as were willing to go. Army trucks were provided to take them and their luggage to the trains. By train they proceeded to one of the two transit camps established — either Lubeck, whence they went by boat to Gydinia in Poland, or Hesslingen, thence by train through the Russian Zone of Germany into Poland.

From the assembly centre to the transit camp the nurse had an important part to play in the repatriation program. To begin with, she was responsible, under the supervision of the doctor, to see that all DPs were dusted with DDT powder; that they

were free from communicable disease; and that no person obviously ill was included in the group. The nurse also had to be sure that the mothers had adequate supplies of food for infants and young chil-Each train carried about twelve hundred DPs and one nurse and two nurse aides travelled to the transit camp with each train group.' The nurse took with her a first-aid kit and an emergency maternity kit. Although no woman more than six months pregnant was permitted to be included in the departing group, it was sometimes found that if the husband was going the expectant mother managed to sneak into the repatriation train! At all rest stations and feeding halts the nurse and her assistants travelled the whole length of the train, checking especially on the condition of mothers and young babies. This service was greatly appreciated by the DPs, who

felt that there was someone who was taking a real interest in their welfare until they left the tragic soil of Germany. The Flying Squads, it may be mentioned, serviced the feeding halts, and also provided a small dispensary for the distribution of medical necessities. At the transit camp at Lubeck, or Hesslingen, there was a waiting period of from twentyfour hours to several days. Here a well organized nursing service was provided to care for them while in camp and to meet in advance the possible needs for the remainder of the After the transit camps, journey. UNRRA personnel relinquished the care of the DPs to their own countrymen and were permitted to accompany them no further.

MANY NATIONS

I cannot conclude without mentioning the nursing representatives of other organizations working in the British Zone. The British Red Cross Society, while working under the sponsorship of UNRRA, was responsible for the administration of a certain number of assembly centres and, as mentioned previously, controlled a number of hospitals for the care of DPs. The principal matron of the British Red Cross Society and all her staff were most capable and co-operative colleagues. One of the centres for the nurse aide course previously mentioned was located in the Red Cross hospital There, the staff, in at Darup. addition to providing facilities for instruction, took a very great personal interest in the DP girls, an important contribution both to their instruction and their rehabilitation. Attached to the Control Commission for Germany (British Element) were two principal nursing advisers, whose responsibility it was to help rebuild the Germany nursing services. UNRRA nursing adviser, it was my privilege to establish a Nursing Advisory Committee, of which the principal nurses of these two organizations were members. From them much helpful advice was obtained in various aspects of the nursing programs and



Feeding the travellers

they kept us informed also of developments in their own services — there was, in fact, a mutual interchange of information that was most valuable.

Since I left Germany, the policy of turning over as much as possible of the work of the nursing service to the DP nurses and nurseaide personnel has been continued. and the reduced staff of UNRRA nurses has acted more and more in supervisory and administrative capacities. In some small measure, we hope and believe, this has enabled many of the displaced persons to escape the sense of frustration which was so apparent among them, and to undertake something constructive not only to themselves, but something that permitted them to contribute quite obviously and satisfactorily to the welfare of their own groups. We hope, also, that what they have learned professionally will be of value to them when they return to their homeland or settle ultimately in some new country, and that, on the bases that have been established, they will continue to build further.
For the UNRRA nurses from the

For the UNRRA nurses from the many countries represented, this unusual experience, which we trust need never be repeated in human history, has been, indeed, a most gratifying and interesting one. It was an opportunity to give service to people in dire need, and it was most satisfying to see the immediate results of one's personal work under circumstances of such urgency. In addition, the contact with nurses and other professional workers from the various countries, and the study of their

standards and methods was most stimulating—it was an opportunity, indeed, to examine and revise one's own methods. Further, as a Canadian, I am glad to be able to say — as I think it should be said — that there was great satisfaction in realizing that the professional standards in our own country are second to none in the world.

South African Nurses Visit Canada

Of special interest to Canadian nurses who served with the South African Military Nursing Service will be the news of the visit to Toronto of Miss C. Nothard, Matronin-Chief of the S.A.M.N.S., during the war, and her assistant at that time, Miss G. Borchards.

After flying from Johannesburg to New York to be two of the official South African delegates to the I.C.N. Congress in Atlantic City, they proceeded to Toronto at the invitation of the "Canadian Springboks," those now resident in Ontario who served with the S.A.M.N.S. Plans for the two-day visit, which included a motor trip to Niagara

Falls, were ably arranged by Miss Helen Frost, president of the group, Mrs. Helen Holm, secretary, and Miss Mary Ball.

The highlight of the stay was the informal banquet, held at the Royal York Hotel, when Miss Nothard told of the chair of Nursing to be established at Witwatersrand Universitý in Johannesburg and its counterpart for Afrikaans students at Pretoria University. Both guests told some amusing incidents of the royal visit to the Union and gave interesting observations of the I.C.N. meeting. They expressed pleasure at being asked to meet the Ontario group and to see something of Canada.



The Celebration Dinner

Townson & Ibbotson, Toronto

Important Announcement!

The Educational Policy Committee of the C.N.A. has selected the Metropolitan Hospital, Windsor, Ontario, as the clinical centre for the new Demonstration School. Miss Nettie D. Fidler, the director of the School, is interested to receive applications from suitable prospective students for the first class which will be admitted early in 1948. Write to her in care of National Office, C.N.A., Ste. 401, 1411 Crescent St., Montreal 25.

Fuller details of this project will be published next month.

STUDENT NURSES PAGE

A Student Reports on the I.C.N. Congress

ZETA MUNRO

Student Nurse, Toronto Western Hospital School of Nursing

It was a very great privilege for a student nurse to attend the Congress of the International Council of Nurses held in Atlantic City, N.J., May 11-16, 1947. This year marked the first occasion that students were allowed to attend, and it was indeed a most thrilling experience. I have been asked several times if we found it heavy and above our heads. Heavy? Most certainly not. While we were perhaps lacking in background and experience, yet I'm sure we made up for that with extra enthusiasm.

The I.C.N. was first organized in London, Eng., in July, 1899, by Mrs. Bedford Fenwick. Mrs. Fenwick died March 13, 1947, at the age of ninety-two. She will always be remembered for her outstanding work in the advancement of nursing. Owing to the war, the last session of the I.C.N. was in London in 1937, and now plans are underway to hold the next congress in Sweden in 1949. That year will mark the fiftieth anniversary of the I.C.N., which is the oldest international organization of professional workers in the world.

There were forty countries represented with an opening attendance of over six thousand. Students were present from Brazil, England, Norway, U.S.A., and Canada. The Americans had representatives from twenty-eight states, but Canadian schools were poorly represented. When we checked the register we found there were two students from Winnipeg, and one from each of the

following Ontario schools: Sarnia General; Victoria, London, Ont.; Ontario Hospital, New Toronto; and Toronto Western Hospital.

The meetings were all held in the Convention Hall, which is the largest of its kind in the world, and it is truly a magnificent building. The main auditorium seats over sixty-five thousand people, and the acoustics are flawless.

Each day was divided into morning, afternoon, and evening sessions. In the morning and afternoon, two sessions went on simultaneously. These followed the same pattern. A paper was presented by some outstanding person and the next hour was devoted to an open discussion period. In the recess periods, everyone visited the extensive exhibit booths set up in the entrance of Convention Hall. All the well-known drug companies, publishing houses, etc., were represented. They had marvellous literature on the latest drugs and research work, and were most generous with samples and literature.

Beyond this part was the General Assembly Hall with its huge platform. In the centre was a beautiful, colored portrait of Florence Nightingale flanked on either side with flags of the countries represented. The front was a mass of flowers, and at one side was the pipe organ which was a masterpiece in itself. When we entered the first morning they were playing "Oh, what a beautiful morn-

SEPTEMBER, 1947

ing." That, combined with a previous walk along the boardwalk in the sun and glorious ocean air, certainly made

an unforgettable setting.

Miss Effie Taylor, the president, presided and the platform was filled with guest speakers for the opening session. After a prayer for deceased nurses, Miss Taylor read a letter from the President of the U.S.A. This was followed by brief but dynamic addresses by leading surgeons of the States. Dr. Brock Chisholm, executive secretary of World Health Organization, was very good.

"A nurse can put a patient back on his feet the way no doctor can. She represents to the patient a heart, and not a science. She represents peace and protection."

Mrs. Mary Norton, Congresswoman for New Jersey, was outstand-She stressed the necessity of developing the art and habit of thinking. She begged nurses to take an active part in international affairs and to get way from just being nurses. "Develop above all," she concluded, "Faith in God, the world and yourselves. With that done, you can accomplish anything."

RÉSUMÉ OF OUTSTANDING PAPERS

M. Bihet, of Belgium, presented a paper on "Professional Education." She stressed the point that the moral factor is one of the most important

in a nurse's education.

"A nurse must possess besides her profession, a well formed character, a straight conscience, and a strong sense of responsibility. Criticism made against the younger generation is lack of responsibility. The cause of this can be traced to a great extent to the present system of teaching. While the whole organization has reached a high standard of teaching and demonstration, yet we have cut and interrupted the practical experience a student must have to become an efficient nurse."

Miss Mary Mathewson, director of nurses at Montreal General Hospital, pleaded with nurses to devise a means of improving basic and graduate programs, since "present methods do not

produce desired results." She warned that we ourselves know best what can and must be done to improve our programs, and that we should decide before it was done for us. She pointed out that the pendulum had swung from mass unemployment to incredible shortage. She urged continuing education for those already in the administrative field, and to broaden courses for beginners. "If we believe that the true purpose of education is to develop human beings who have learned to see, hear, feel, think, and use their native ability, then most of us will agree that our present methods do not produce the desired results."

Miss Ethel Johns stated in her address that international nursing implies that nurses go to other countries to seek further knowledge, and in return that country sends her nurses back. Read Miss John's remarks regarding the age in which we are living which is printed in full in

this issue.

The following paragraph taken from a paper on "Fundamentals of Ethics" should be of interest to every student:

"Remember that the student is more than a nurse; a human being who has the normal destiny of all other human creatures. Before she is a technician, the nurse is a woman. Her professional life must integrate in both these two general ends. not so, her personality shall be disturbed, and normal fullness of her life impeded."

STUDENT ACTIVITIES

A general meeting was held at the beginning of the week in order to become acquainted. It was quite informal and we merely discussed rules and regulations of different schools, and also the necessity of a wider social life. There were three male students present from Chicago. We accepted an invitation to a buffet luncheon given by the Atlantic City student nurses, which again afforded us the opportunity of meeting by ourselves. There were approximately 180 students at these meetings.

Several American students were



- 46 YEARS OF "KNOW-HOW"...
- 70 Different tests and inspections behind it



Nothing you prescribe is made with more attention to detail than Aspirin. To insure the quality, uniformity, purity and quick disintegration for which these tablets are famous, over seventy different tests and inspections have been evolved. The prestige that Aspirin enjoys was earned over a period of forty-six years by making a truly fine product.

"ASPIRIN"

THE ANALGESIC FOR HOME USE

Aspun is the registered trademark in Canada of the Baser Company Limited

anxious to learn how our students raised funds to send a representative, and were quite interested to hear of our plans at Western. Early in April a program was commenced. This included a short play, with various musical numbers. When the program was finally presented, we found that we had raised sufficient money to finance the trip. Might I add here that it is an excellent method for any school to adopt, and it creates a wonderful school spirit.

SOCIAL EVENTS

In keeping with tradition, the American Nurses' Association played the role of ideal hostesses for their many guests. Every evening was ex-

ceptionally well planned.

A formal reception at the Ambassador Hotel started the busy round of events. It was fascinating to see the native dresses of the representatives from such countries as China, Switzerland, and the Philippines. I was particularly impressed by two Philippine nurses who wore stiff organdy dresses in yellow and pink. Dashing around from one group to another, they reminded me of butterflies. It was a great honor at this reception to meet, among others, Miss Schwarzenberg and Miss Hojer the new president. Other evenings were devoted to musical entertainment, when we were privileged to hear the Philadelphia Festival Orchestra, the Lincoln Male Choir, and the Westminster Choir.

One of the highlights of the evening entertainment was the Florence Nightingale Oration and the presentation of Citations. Those honored

were Miss Annie Goodrich, one-time president, now honorary president, and Miss Lavinia Dock who was the first secretary of the I.C.N. It was the same Miss Dock who, with Miss Adelaide Nutting, wrote the famous book on the history of nursing. When Miss Taylor introduced Miss Dock, she described her as being a musician. painter, and crusader for woman suffrage and social hygiene. Miss Dock, of very slight stature, and attired in a long black dress with ruffled white neck-piece and little frilly cap, was most witty and kept her huge audience well entertained. When Miss Taylor spoke of her as a musician, she put up her hand in a gesture of dismay, and said, "That was my sister." Then in a loud, high-pitched voice which certainly belied her ninety years, she told us how nursing had advanced through the years.

The I.C.N. closed with a brief morning session on May 16. The program was composed chiefly of votes of thanks from visiting countries, and

the president's address.

The entire convention was a thrilling experience, and a challenge to every nurse there. Especially was this so for students. We are facing the future now just as Miss Dock did many years ago. Will we be able to look back when we reach her grand old age with as much pride as she, for what we have contributed to the nursing profession? I hope so.

And now may I pass on to fellow students across Canada this inspiring thought which was left with us in the

closing address—

Faith is a bird which sees the light, And sings when the dawn is dark.

Sinus Inhections

The ideal treatment in the early stages for an attack of acute nasal or sinus infection, includes rest in bed in a warm moist room, the alleviation of symptoms by the use of a drug to relieve pain, and decongestants instilled or packed into the nostrils to enlarge the breathing space and to promote drainage. Vasoconstrictor drugs have a limited use in these infections. In many cases they may be actually harmful. If used to provide temporary relief in cases of extreme nasal blockage, their prolonged use should be discouraged. They are seldom, if ever, indicated in chronic infections.

—Digest of Treatment



Women Volunteer to Aid Hospitals

KATHLEEN COURLANDER

A splendid response is being made by London housewives to an appeal by Sir Wilson Jameson, chief medical officer of Britain's Ministry of Health, for those who have been trained as nurses and midwives to come forward and give part-time services in local hospitals during the next few months. Sir Wilson's appeal was issued during a weekend and certain hospitals opened recruiting bureaux on the Sunday of that period. Despite the bad weather and difficult conditions prevalent in Britain at the time, there was a steady stream of women who wanted to help. Within six days there had been over six hundred volunteers and the roll increases daily. In addition to trained nurses and midwives, other housewives came forward and undertook to do ward orderly work in the hospitals - that is, they volunteered for domestic duties which at present, owing to staff shortage, have to be undertaken by trained nurses. These women, although not trained nurses, have had some experience in nursing and a certain amount of tuition which was acquired during World War II in the British Red Cross or as members of the Women's Voluntary Services. The Ministry of Health officials are pleased

with the results of the appeal which will do much to assist the national welfare during the coming months.

The reasons for this appeal are due to a steady mounting of Britain's birth-rate and a shortage of nurses to care for mothers and babies.

BIRTH-RAIF RISING

During the last year, Britain's birthrate has been steadily increasing. In the first quarter of 1946 the number of babies born in England and Wales was 186,623 and every successive quarter last year this number rose steadily. It is estimated that from January 1 to the end of March, 1947, the number of births will be 228,000, about 6,000 more than in the previous quarter. Of these babies, 42,000 infants are likely to make their appearance in Greater London, which means that there will be about one thousand more new citizens of the metropolis than in the last quarter of 1946.

Britain's Ministry of Health for some time has urged young women to adopt nursing as a career but, although many thousands have responded, there are not enough nurses in the hospitals to care adequately for all these mothers and babies. Therefore, Sir Wilson Jameson, is appealing to the house-wives in Greater London to go and help in the hospitals by a system of part-time work. If a sufficient number of women undertake duties on four-hour shifts, 7,394 beds, which at present must remain empty owing to the shortage of nurses, will be filled.

RELIEVING TRAINED NURSES

Those who before marriage were trained as nurses or midwives are particularly asked to help, but other women are required, who, though not skilled nurses, are able to act as hospital orderlies and relieve trained nurses of the domestic work they now have to undertake.

"This sharp rise in the birth-rate has thrown a tremendous strain on the maternity services in the capital," said Sir Wilson. "It may be that we are now at the peak of the postwar services. The need for midwives is even more acute than the need for more nurses. I am concerned with a new, immediate possibility — that of helping London's hospitals and maternity institutions over this difficult period of getting back, for part-time work, some of the thousands of nurses who have retired into private life on marriage, or because they have reached an age when they no longer feel up to a full-time job."

Sir Wilson explained that this scheme had been tried out in the county of Gloucestershire and now there was even a waiting-list of nurses ready to help in the local hospitals and institutions for old people.

"During the next few months," added Sir Wilson, "the hospitals in Greater London want all the part-time help they can get. There is a serious shortage in the municipal hospitals, in the smaller hospitals, and the hospitals for old people. We want trained women of all ages to come back to midwifery and all branches of nursing, including mental nursing. Of course, it is useless to expect the part-timer, who has private and domestic ties, to fit into the normal hospital routine,

unless it is adapted. The part-timer needs special consideration and assistance on hours, meals, and transport, and the hospitals are willing to fit in with these needs so far as they possibly can. They are paying special attention to the provision of meals and to the provision and laundering of uniforms. If a woman can give only one shift of, say, four hours a week, and provided she can do it regularly, then we want her to volunteer.

"I believe there are large numbers of retired nurses and midwives in the Greater London area who will come back to the hospitals in their present plight . . . the hospitals of London are managing to care for their patients only because their nursing staffs are working longer and harder than they ought to work.

"In the maternity institutions, parttime midwives can, by giving help for a few shifts a week, ensure that the fulltime midwives have more time for training mothers in the care of their babies.

"No nurse or midwife need be afraid to volunteer because she has not been in practice for a long time and feels a bit 'rusty.' For instance, a midwife who has been retired for a long time would feel nervous of taking charge of confinements, but she will not be asked to do this until she is ready, and can be a maternity nurse."

Five London hospitals have opened special reception offices to welcome women volunteers. In addition, a Ministry of Labor Resettlement Advice Officer and other recruitment centres are available to give details of the scheme. The new part-time workers are enjoying improved rates of pay recommended by the Rushcliffe Committee, under which, for example, a midwifery sister, who recently had 2s. 3d. an hour, will now be paid 3s. an hour, and a staff midwife 2s. 1d. hourly instead of 1s. 9d. There are other corresponding increases.

The scheme is likely to extend to all parts of England and Wales in the near future.

Anti-Tuberculosis Survey

What is believed to be a world's record for cities was achieved by Swift Current, Sask., in a recent anti-tuberculosis survey, when 96.3 per cent of the population was examined by x-ray.

"People have responded enthusiastically, and while we have not yet received final figures on many of the municipalities, with few exceptions those which have been surveyed have gone well over the 90 per cent

mark in attendance. The city of Swift Current achieved what is believed to be a world record for cities in such a survey, with an attendance of 96.3 per cent. Several villages and hamlets have had 100 per cent attendance," the report said.

"The results of this survey are an indication of how co-operation can become an effective instrument, with the services available in a health region working in conjunction with the Anti-Tuberculosis League facilities, strongly backed by public opinion within the region."

That Word Again

Even amid national crises, the London Times could not bear to leave the ramparts of the King's English unmanned. Last week the Times fired away at the word "personnel," "this alien collective" from across the Channel. It doubted that "a more degrading, a more ill-favored synonym for two or more members of the human race has . . . been coined."

"People to whom it is applied," said the Times, "do not go, they proceed. They do not have, they are (or, more often are not) in possession of. They do not ask, they make application for . . . They cannot eat, they only consume; they perform ablutions; instead of homes they have places of residence in which, instead of living, they are domiciled. They are not cattle, they are not ciphers, they certainly are not human beings; they are personnel."

- Times Magazine.

Crude Liver Extract

The death rate from cirrhosis of the liver, which has always been high, can be reduced through treatment with crude liver extract, it has been discovered by four New York physicians who treated 30 patients. They reported a survival rate over a two-year period of approximately 77 per cent.

Previous investigators, who observed a comparable number of patients with symptoms of late stages of the disease, reported the survival rate over a similar period to be approximately 45 per cent when the patients were treated by diet and vitamins, 22 to 25 per cent among untreated patients, and 65 per cent for patients treated with



Readily Digestible MILK MODIFIERS for INFANT FEEDING

Crown Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.



"CROWN BRAND" and "LILY WHITE" CORN SYRUPS

Manufactured by THE CANADA STARCH COMPANY Limited
MONTREAL AND TORONTO

the more refined liver extract through injection into the veins. Incidentally, the crude liver extract was given in the same manner.

Cirrhosis of the liver is commonly found among heavy alcoholic drinkers, but it also may occur in total abstainers. In the group treated with crude liver, 21 patients were chronic drinkers.

When the liver becomes cirrhotic, its cells degenerate and are replaced by scar tissue. As a result, the blood vessels in the liver become constricted and the blood stagnates in them. Eventually cirrhosis causes the serum to ooze out of the swollen veins and to produce swelling of the abdomen. This condition, ascites, found in 21 patients before treatment was begun, necessitates draining off the liquid from the abdomen. Also, the

veins in the esophagus may become dilated and hemorrhage where this food-carrying canal enters the stomach. Seven patients in the group had esophageal hemorrhages.

The crude liver extract was injected into the veins of the patients two or three times a week for six months or longer. No strict supervision of diet was undertaken, but patients were not allowed to drink alcoholic beverages. They were instructed to select foods high in protein and rich in carbohydrate. No foods were prohibited if they were tolerated without distress.

In addition, if the patient exhibited a vitamin B deficiency, supplements of the vitamin B group were prescribed only long enough to overcome the deficiency.

- Health News Service

Paralysis In Polio

About 20-35 per cent of proven cases of infantile paralysis are of the abortive type in which there is no paralysis of muscles at any time. About 30-40 per cent of those cases which are paralyzed make a spontaneous recovery. On the whole, therefore, 50-75 per cent of the cases in any epidemic make a complete recovery without residual paralysis.

—Digest of Treatment

School Enrolment

As a result of the war and postwar boom in births, our country will have a record number of children at the school ages in the 1950's. The effect of the rise in the birth-rate is already noticeable in the lower grades of the schools and it will be felt with increasing force in the years to come. The maximum should be reached by 1953.

-M.L.I.C. Statistical Bulletin

Book Reviews

Textbook for Psychiatric Attendants, by Laura W. Fitzsimmons, R.N., B.S., M.A. 332 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Price \$3.50.

Reviewed by Ella G. Smith, Superintendent of Nurses, Ontario Hospital, Kingston.

The author has written the book in two divisions. The first division consists of a brief history of psychiatry which gradually wends its way to Twentieth Century progress. The various types of hospitals for the care of the mentally ill have been concisely described. The writer then accepts the opportunity to outline, first, the attitude of the attendant with relation to his work and, secondly, the relationship which he is able to develop between himself and his patient. Special problems associated with mental patients have been thoroughly discussed in simple terms and will be helpful to all psychiatric attendants. The special therapies have been so described as to make each attendant realize the importance of carrying out the treatments according to the physician's order.

The second division deals with treatments and nursing care. It is possible that criticism may be forthcoming in regard to the teaching of advanced nursing procedures. However, it is well to analyze the situation when circumstances may necessitate attendants giving complete nursing care.

In conclusion, the author has indicated her extensive knowledge of the care of the mentally ill. She has placed emphasis on the application of a psychiatric approach to all patients. The attendant's interest should be sufficiently aroused that he will be motivated to read the reference books.

This textbook for psychiatric attendants, together with the previous manual for training attendants, should be welcomed by all instructors who are instrumental in planning and teaching a course in psychiatric nursing.

Health Insurance in the United States,

by N. Sinai, Dr.P.H., O. W. Anderson, and M. L. Dollar. 115 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1946. Price (in U.S.A.) \$1.50.

Reviewed by Monica Frith, Consultant, Public Health Nursing, B.C. Department of Health and Welfare.



are especially prepared

Only pure, carefullytested ingredients are contained in Baby's Own Toiletries . . . based on 75 years of continuous research and experience.



for baby's tender skin



You can safely recommend these extra pure, extra gentle toiletries for any baby. They're worthy of your complete confidence,



The J.B. WILLIAMS CO. (CANADA) LIMITED
La Salle, Montreal



For patients who require concentrated diets

In the concentrated dietary, Klim Powdered Whole Milk can provide the patient with extra calories without materially increasing the bulk of his diet.

Each level tablespoon of Klim supplies 40 calories. It can be blended with a variety of foods in powder form.

For example take children who will not (or cannot) consume a quart of liquid milk daily...by incorporating Klim directly in cooked dishes, or mixing it with dry ingredients, the problem is solved.

Klim concentrated diets are good for children suffering from anorexia. Klim is also valuable in other cases when large food intake is needed such as in typhoid and other febrile diseases, pneumonia, tuberculosis, and postoperative debility.

For professional information about concentrated diets and infant feeding with Klim write: The Borden Company, Limited, Spadina Crescent, Toronto 4, Ontario, Can.





First in preference the world over

The health insurance movement in the United States is presented in factual style by Dr. Sinai and his associates in this little monograph prepared in co-operation with the Committee on Medicine and the Changing Order of the New York Academy of Medicine.

In an accurate and unbiased manner, the growth of medical insurance is traced from the industrial revolution, which brought forth problems of adjustment, and created emphasis on "security" which the authors claim to be "indivisibly joined" with the practice of health insurance.

The movement is developed through its sporadic periods of activity during this century. The authors state that health insurance involves all health professions, embraces government, labor, industry, and the public, and emphasize that, although the principles of health insurance are accepted, the task of effectively applying it has only begun.

The attitudes and recommendations of the various professional groups who conducted studies on the subject are carefully set forth and explained. Enabling legislation and the characteristic features of the voluntary plans are outlined. The many problems which must be considered by voluntary plans before complete health coverage is possible are discussed in relation to security and health.

In conclusion, the authors point out that the day of broad recommendations is past and that the chief issue today involves the organization and administration of a national health scheme. Those interested in the subject will find this brief outline most helpful in consolidating their views on health insurance.

A New System of First Aid, by R. C. C. Clay. 188 pages. Published by Faber & Faber Ltd., 24 Russell Sq., London W.C. 1, Eng. 1946. Illustrated. Price 5s.

For many years those who have taught or have been taught first aid have used well-known manuals which have described, categorically, the steps that should be taken in caring for an injured person. Dr. Clay states in his introduction: ". . . almost without exception the patient is not in much pain unless somebody has moved him. The aim of First Aid should be to get that man to hospital without causing him pain. Pain means movement of injured parts, and so further harm to the patient."

"There are three main divisions in First

THE CREAM with many uses



Nivea Creme should have a permanent place in every nurse's cupboard. It serves all cosmetic purposes and also has valuable soothing properties. Nivea is different from other creams because it contains Eucerite, a substance that closely resembles the skin's natural fatty elements. Aided by Eucerite, Nivea penetrates the epidermis and feeds back into the skin the nourishing elements taken out by washing, antiseptic fluids, chafing and daily wear and tear. For very dry skins, and for massage, use Nivea Skin Oil.

Manufacturel in Canada by NIVEA PHARMACEUTICALS LIMITED Distributing Agents VANZANT & COMPANY 357 College Street, Toronto Skin needs NIVEA

FOR SKIN-HEALTH AND BEAUTY

'Nivea' and 'Eucerite' registered Trade Marks

(C.31)

Aid: Immediate Aid, First Aid proper, and Second Aid." The detailed instructions which are outlined for various forms of injury are based on this different concept. Much more emphasis is placed upon the importance of not altering the patient's position unless it is absolutely necessary. "Ten minutes is the maximum time to take over a seriously injured man." "A quickening pulse is the first warning of shock." Immediate aid to prevent shock and the complete immobilization of injured areas are stressed.

Those who have struggled to master the intricacies of applying the ordinary large arm sling will appreciate Dr. Clay's objections to it: "The ordinary large arm sling does not support an arm when the patient is lying down, because in that case the patient's neck is lower than the injured arm. In fact, the patient's neck is supported by the arm. Nor does the ordinary large arm sling prevent the arm from falling sideways. It does not prevent the arm swinging forward when the patient bends. It does not prevent jarring of the arm if someone knocks against the elbow. To sum up, it does not immobilize the arm above the elbow, which is the only way of effectively immobilizing the forearm or hand."

Procedures are considerably simplified in

this little manual which should result in greater skill on the part of the first aider and less risk for the patient. Not so profusely illustrated as the manual to which we are accustomed, there are pictures of many of the different practices which are advocated.

Law and the Practice of Medicine, by Kenneth George Gray, M.D., B.Sc. (Med.), K.C., E.D. 68 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1947. Price \$1.50.

Few nurses have much knowledge of the relationships of medical practice to the laws of our land. While Dr. Gray's book has special application to the medical profession, the definition and explanation of the legal problems, which most frequently confront doctors and hospitals in Canada, include much that bears upon the nursing profession as well. For example, under Actions of Negligence, Dr. Gray states:

"The principles applicable to medical practitioners apply to members of the nursing profession, that is, a nurse who negligently injures a patient may be held liable in an action brought by the patient."

Does the law require that consent forms must be signed before an operation is performed? How is a nurse protected in the



TEETHING!

Yes, to keep your baby smiling and happy, make sure the little system is working just right. Avoid troubles at teething time by giving Steedman's Powder. This famous English remedy gently regulates the little system. Keeps baby from being feverish and fretful. At your druggist's.

Mother praises Steedman's — "I have 7 children, and they have had nothing but Steedman's while teething."

FREE BOOKLET

"Hints to Mothers"
Write John Steedman
& Co., Dept. F-1, 442
St. Gabriel Street,
Montreal.



Look for the double EE symbol on the package.

event that she is required to give evidence regarding matters which she regards as professional confidences? These and numerous other questions are answered concisely and directly in this brief summary of the legal tomes. It is a book which might well be included in every hospital or public health organization library.

Dr. Gray is lecturer in medical jurisprudence and forensic psychiatry at the University of Toronto and medical-legal adviser to the Department of Health and Hospitals of Ontario.

Alberta

The following are recent staff changes in the Division of Public Health Nursing, Alberta Department of Public Health:

Appointments: F. Ferguson (Royal Alex-

andra Hospital, Edmonton), ex-nursing sister, as registrar-consultant with the School for Nursing Aides, Calgary, operated by the Department of Public Health and Canadian Vocational Training; D. Taylor (Royal Alexandra Hospital, Edmonton) to Lindale for summer; Alberta Lewis (Calgary General Hospital and University of Alberta public health course) to Bow Island.

Transfers: M. Weder from Lindale to Smith.

Resignations: Mrs. A. Cavil, formerly at Lomond, from the staff; Beth (Laycraft) Tachit from the staff; B. Taylor from Maloy to be married; Mrs. A. Glasgow from Wainwright; M. Dunbar from Bow Island.

Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia: Christine Campbell (Royal Victoria Hospital, Montreal; R.C.A. M.C.) appointed to administrative staff as assistant supervisor of Outpost Hospital Department. M. J. Aitkens (Royal Jubilee Hospital) has resigned from McBride Outpost Hospital to continue her studies and Gladys Keilty (Royal Inland Hospital, Kamloops), who was on the staff, is nurse in charge. Mrs. John (Whitlam) Peace (St. Paul's Hospital), of Cecil Lake Outpost, Peace River Block, has resigned and is succeeded by Christina Ford (Queen Victoria Hospital, Revelstoke). Bertha Jenkins has resigned as matron of Kyuquot Outpost Hospital to take charge of King's Daughters Hospital, Duncan, and Janet Card (Clifton Springs, New York) will succeed her.

New Brunswick: Annie Carr (Montreal General Hospital) has replaced Patricia Wood (Saint John General Hospital) at Grand Manan Outpost Hospital. Shirley Horton (Moncton Hospital) is also on the staff while Helen Christian has resigned as superintendent. Florence Keswick of Richibucto succeeds Harriet Hughes as superintendent of Kingston Hall Community Hospital, Rexton, who has been granted leave of absence.

Ontario: Mary Donoghue has completed her course in administration at McGill School for Graduate Nurses and is temporarily on duty at Hornepayne as is Mrs. C. Hoye. Patricia Leuty has been transferred from Beardmore to Espanola. Mary Anderson (Torbay Hospital, England; graduate midwife) is at Hawk Junction while Mrs. Gwen

Ridley is at Emo. Mrs. Marie Phiilips has been transferred from Bracebridge to temporary charge work at Beardmore. Vera Griffey and Marietta James (Hamilton General Hospital) are doing summer relief at Bancroft as is Mrs. Eva Porter of Wiarton. Ruth Gardner (Hamilton General Hospital) and Frances Fardella (Hotel Dieu, Kingston) are at Dryden and Betty Chinn (Royal Alexandra Hospital, Edmonton), who is studying medicine at Queen's University, is doing summer relief at Atikokan. Mrs. Teresa Wright, who has been at Thessalon, is now at Bracebridge.

Saskatchewan: Ruby Tinkiss, Division of Maternal and Child Hygiene, Department of National Health and Welfare, will organize a Red Cross Breast Milk program in Regina.

M.L.I.C. Nursing Service

The following is information concerning staff changes in the Nursing Service of the Metropolitan Life Insurance Company:

Appointments: Claire Bernier (Hotel-Dieu Hospital, Montreal), Simonne Cadieux (Sacred Heart Hospital, Hull), Alice Comtois (Sacred Heart Hospital, Montreal), to the Montreal staff.

Transfers: Emilienne Dion (Hospital of Infant Jesus, Quebec City, and University of Montreal public health course) from Montreal to take charge at St. Jerome, P.Q.

Resignations: Liane Chevalier (St. Jean de Dieu Hospital, Gamelin) as nurse in charge at Joliette, P.Q.; Faustina Fournier (Ottawa General Hospital and University of Ottawa public health course) and Antoinette Vachon (Hospital of Infant Jesus, Quebec City), from Montreal.

Angeline Caron (Notre Dame Hospital, Montreal, and University of Montreal public health course) has resumed her duties at Montreal after an absence of two years.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: Helen Etherington (St. Catharines General Hospital and University of Toronto) as public health nursing supervisor with Welland and district health unit; Jenny Berry (Kingston General Hospital and Universities of Western Ontario and Toronto) as public health nursing supervisor with Kirkland-Larder Lake health Unit, succeed-



- An OPPORTUNITY
- A CHALLENGE
 60 Graduate Nurses
 for Indian Hospital
 and Field Duty

Expansion of modern hospital and public health services to Canada's Indians requires additional nurses to meet the challenge of this humanitarian work.

Vacancies.

Brantford Norway House
Manitoulin Island Battleford
Port Arthur Qu'Appelle
Kenora Edmonton
Winnipeg Prince Rupert
Sioux Lookout Nanaimo

Sardis

Salary:

Up to \$167 per month, less maintenance if provided. Extra salary for operating room, night supervisor and public health nurses.

Write to:

MR. J. C. RUTLEDGE,
Department of National Health and
Welfare,
Birks Bldg., Ottawa, Ont.

Good News About Nursing Texts

Macmillans are glad to remind you that ample stock is available of the two standard nursing texts:-

*Kimber, Gray and Stackpole, ANA-TOMY AND PHYSIOLOGY FOR NURSES \$4.00.

and

Harmer and Henderson, PRINCIPLES AND PRACTICE OF NURSING \$4.00.

THE MACMILLAN COMPANY
OF CANADA LIMITED

70 Bond Street, Toronto, Ontario

REGISTRATION OF NURSES

Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on November 19, 20, and 21.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

The Director,
Division of Nurses Registration
Parliament Buildings, Toronto 2

ing Marjorie Pinchbeck (Calgary General Hospital, University of B.C. public health course, and McGill School for Graduate Nurses) who has resigned to pursue postgraduate study; Irene Flanagan (St. Joseph's Hospital, London, and University of Western Ontario certificate course), formerly with Chatham Board of Health, as senior public health nurse with Kent County health unit: Mary Bliss (University of Toronto diploma and administration and supervision courses) and Mrs. Ruby (Cronk) Moss (University of Toronto diploma and administration and supervision courses), formerly senior public health nurse with Brant County health unit, to East York-Leaside health unit: Olive Smith (Toronto General Hospital and University of Toronto certificate course), previously with St. Catharines-Lincoln health unit; to Northumberland and Durham health unit; Lorraine Larsen (St. Michael's Hospital, Toronto, and University of Toronto certificate course), formerly public health nurse with Oakville Board of Health, and Oleavia Chant (Buffalo City Hospital and University of Toronto certificate course), who has held the position of public health nurse with Boards of Health of Milton, Acton, and Georgetown, to Halton County health unit; Dora Purdon (Ross Memorial Hospital, Lindsay, and University of Toronto certificate course), recently resigned from Simcoe County school health service, Mrs. James (Thompson) Dowsley (Oshawa General Hospital and school nursing summer course, Ontario Department of Education), and Eleanor Earle (A. Barton Hepburn Hospital, Ogdensburg, N.Y., and University of Toronto certificate course), formerly public health nurse in Brockville, to Leeds and Grenville health unit; Maxine Ward (B.Sc., University of Western Ontario) as public health nurse with Ontario Hydro Commission, Fraserdale; Mary Nash (Victoria Hospital, London, and school nursing summer course, Ontario Department of Education), formerly with Windsor Board of Health, as public health nurse with school service in Township of Sandwich East and Town of Tecumseh, succeeding Ernestine Duchene (Toronto Western Hospital and school nursing summer course, Ontario Department of Education) who resigned.

The following graduates of the certificate course in public health nursing at the University of Toronto, 1946-47, have accepted appointments:

Vida Abbott (Brantford General Hospital),

Bertha Klassen (Saskatoon City Hospital), Jennie Lostracco (St. Joseph's Hospital, Hamilton), and Janet Turnbull (Toronto General Hospital) with Kent County health unit; Audrey Anderson (Women's College Hospital, Toronto) and Marian Higginson (Toronto Western Hospital) with Halton County health unit; Helen Arkell (Toronto General Hospital), Mary Rust (Toronto General Hospital), and Beatrice Whalley (Hamilton General Hospital) with Bruce County health unit; Georgina Bailey (Toronto Western Hospital) and Pearl Sewell (Owen Sound General and Marine Hospital) with Lennox and Addington health unit; Evelyn Dougher (Mack Training School, St. Catharines General Hospital) with Northumberland and Durham health unit; Jane Minott (Toronto Western Hospital) with Prescott and Russell health unit; Mrs. Jean Phillips (Victoria Hospital, London) with Dufferin County health unit; Ruth Roszell (Toronto General Hospital) with Simcoe County school health service; Dorothy Read (Niagara Falls General Hospital) and Lucille Riley (St. Michael's Hospital, Toronto) with Leeds and Grenville health unit; Margaret MacMillan (Toronto General Hospital) with Copper Cliff Board of Health; Jessie Timleck (Ontario Hospital. Kingston) with Kingston Board of Health.

The following graduates of the certificate course in public health nursing at the University of Western Ontario, 1946-47, have accepted appointments:

Mary Campbell (St. Joseph's Hospital, London) with Windsor Board of Health; Geraldyne Fisher (Hospital for Sick Children, Toronto) with Peel County Health Unit; Ila Wilton (St. Thomas Memorial Hospital) with Elgin-St. Thomas health unit.

Resignations: Bernice McMackon (Royal Victoria Hospital, Barrie, and University of Toronto certificate course) from Kirkland-Larder Lake health unit; Shirley Allen (Victoria Hospital, London, and University of Western Ontario certificate course) and Mrs. Hazel McNeil (Grace Hospital, Detroit) from Oxford County health unit; Deborah Pearce (Hamilton General Hospital and University of Western Ontario certificate course) and Margaret Rattray (St. Catharines General Hospital and University of Toronto certificate course) from Brant County health unit; Ena Campbell (St. Paul's School of Nursing, Vancouver, and University of Toronto certificate course) from Peel County health unit; Ann Sumka (St. Boniface Hospital, Man., and

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to: Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. Q.

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

THE VICTORIAN ORDER OF NURSES FOR CANADA

Has vacancies for supervisory and staff nurses in various parts of Canada.

Applications will be welcomed from Registered Nurses with post-graduate preparation in public health nursing, with or without experience.

Registered Nurses without public health preparation will be considered for temporary employment.

Scholarships are offered to assist nurses to take public health courses.

Apply to:

Miss Maude H. Hall Chief Superintendent 114 Wellington Street Ottawa.

McGill University School for Graduate Nurses

- Degree Courses-

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

One-Year Certificate Courses—

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses 1266 Pine Ave. W. McGILL UNIVERSITY, MONTREAL 25

UNIVERSITY OF MANITOBA

Post-Graduate Courses for Nurses

The following one-year certificate courses are offered in:

- 1. PUBLIC HEALTH NURSING
- 2. TEACHING AND SUPERVISION IN SCHOOLS OF NURSING
- 3. ADMINISTRATION IN SCHOOLS OF NURSING

For information apply to:

Director School of Nursing Education University of Manitoba Winnipeg, Man. McGill University certificate course) from East York-Leaside health unit; Mrs. Phyllis Reynolds (University of Toronto diploma course) from Woodstock Board of Health: Mrs. Margaret (Boyes) Erickson (Vancouver General Hospital and University of B.C. public health course), Mrs. Winifred (Hay) McNaught (Collingwood General and Marine Hospital and University of Toronto certificate course), and Elaine Crosscombe (Toronto General Hospital and University of Toronto certificate course) from Kingston Board of Health; Mrs. Nora Cunningham (St. Luke's Hospital, New York, and University of Toronto certificate course) as public health nurse with Orillia Board of Health; Margaret Lillie (Toronto Western Hospital and University of Toronto certificate course) from Nepean Township Board of Health.

Nursing Sisters' Association of Canada

At the biennial meeting held in Toronto in June, 1946, it was moved by the Toronto Unit that the National Executive of the N.S.A.C. established a fund for the rehabilitation of nurses in devastated countries to be known as "The Rehabilitation Fund." The donations to date from the various units are: Ottawa, \$1,000; Toronto, \$500; Vancouver, \$500; Kingston, \$250; Saint John, \$100; Halifax, \$100; the gift of Col. Agnes Neill, \$600. At the July meeting of the National Executive, \$500 was voted for the British Nurses Relief Fund, \$200 of which was spent to purchase window drapes for Rest-Break Homes at Barton-on-Sea, England. All units have been collecting and sending cotton uniforms to British and European nurses.

The Brandon Unit, although consisting of only twelve members, is keenly interested and maintains an active part in the association. M. Cascaden serves as president with B. M. Long as secretary-treasurer.

The Calgary Unit has a paid-up membership of 68 members, who are sending a monthly food parcel to Britain and have in the past sent food and clothing parcels to British and Dutch nurses. The president is Mrs. S. Nelson and E. M. Perkins is secretary-treasurer.

The membership of the Edmonton Unit stands at 94 and includes nursing sisters from the three services. The banquet, celebrating the 26th anniversary of the N.S.A.C., was a VOLUME 43 NUMBER 10 MONTREAL OCTOBER 1947

CANADIAN NURSE



Chemical Research and Medical Progress

M. M. Cantor, M.D.

1 Some Medicinal Plants

G.H. Hamilton, M.Sc.



(Poliomyelitis

M. McIntosh

Sharing Responsibility

Marie La or



when you nurse yourself

You are naturally discriminating when it comes to choosing what you will take or use for your own minor troubles, so possibly you know already how effective 'Menthofax' can be. If not, it would be a good thing to add to your personal medicine chest, against the time when some unaccustomed exertion has made you stiff, or perhaps when you feel a twinge of rheumatism. Then you will enjoy the sense of warmth and comfort, and the quick relief of pain, which follow massage with 'Menthofax'.



Compound Methyl

Salicylate Ointment B. P. C.

Available in collapsible tubes of % oz., and for clinic use in jars of 1 lb.



Keep Fit!

FOR YOUR JOB ... AND FOR YOUR LEISURE HOURS

with

"NEO-CHEMICAL" FOOD TONIC

> In these busy days of help shortages on hospital staffs, you owe it to yourself to keep fit so you can enjoy both your work and your off-duty hours. NEO-CHEMICAL Food Tonic is the most complete vitamin and mineral food supplement now on the Canadian market. Supplement your diet with this inexpensive source of the vitamins and minerals so necessary to perfect health. Feel your best both on the job-and off!

SPECIAL OFFER TO CANADIAN NURSES

We shall be glad to send you a supply of "Neo-Chemical" Food for your own personal use. Please mention this magazine when writing.

Charles E. Frosst & Co.





The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa.

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

CONTENTS FOR OCTOBER, 1947

Ontario Seeks New Nursing Bill	759
CHEMICAL RESEARCH AND MEDICAL PROGRESS	761
SOME MEDICINAL PLANTS	769
CORAMINE — A LIFE SAVER	774
THE O.P.D. AS A TEACHING FIELD	776
Why I Choose Nursing	777
POLIOMYELITIS	779
Transfers, Discharges, and Methods of Resigning	783
Etude sur la Réhabilitation des Anciens Tuberculeux	787
Notes from National Office	791
Notes du Secrétariat de l'A.I.C.	794
Provincial Annual Meetings.	797
Nursing Profiles.	800
TRAUMATIC LACERATION OF THE ILEUM	804
Book Reviews.	806
Vews Votes	010

Subscription Rates. \$3.00 per year - \$5.00 for 2 years; Foreign & U.S.A., \$3.50; Student Nurses, \$2.00 per year - \$5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address. Four weeks advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible tor Journals lost in the mails due to new address not being torwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.



Johnson's DRAX means less laundering . . . easier laundering!

Here is a completely new and different laundering aid . . . Johnson's DRAX. Not a starch, not a soap, DRAX is an invisible wax rinse that protects fabrics from dirt, soil and water! They stay clean and fresh-looking longer . . . and they're easier to wash!

DRAX... made by the makers of Johnson's Wax... may be applied to any washable fabric: uniforms, curtains, tablecloths, bedspreads. It is easy and inexpensive to use. You need no special equipment or special skilled help. Yet it cuts down on washing time, on washing frequency, on washing costs!

Any institution or concern that uses large quantities of washable fabrics in their equipment will find that it pays to use DRAX. Why not find out about DRAX today!

DRAX

is made by the makers of JOHNSON'S WAX

(a name everyone knows)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

747

OCTOBER, 1947

Reader's Guide

New and exciting experiences are confronting our guest editor for this month. Nettie D. Fidler, president of the Registered Nurses Association of Ontario, has embarked on the long-awaited venture of developing the Demonstration School of Nursing, with the Metropolitan Hospital, Windsor, Ont., as the clinical centre. As if that were not a sufficiently strenuous undertaking, the arduous duties associated with piloting a bill through the provincial legislature will also be Miss Fidler's responsibility. The nurses of Canada will await, with mounting interest, the presentation of the new bill which is unique in Canadian nursing legislation, with both the professional and nursing assistant groups included in the same bill.

The brief announcement last month that the Metropolitan Hospital, Windsor, had been selected as the clinical centre for the new Demonstration School of Nursing has been amplified in the Notes from National Office this month. So that you may be thoroughly familiar with the whole project and able to answer pertinent questions the general public will ask, read this information carefully. It is anticipated that student nurses for the first and subsequent classes in this new school will be drawn from all parts of Canada. In this way it can become a truly national venture.

Plans for the next biennial meeting are taking shape rapidly. An exceedingly interesting and stimulating program is being developed — very different from that of any previous conventions. Read about it in the *Notes* and begin even now to make your plans to attend.

Dr. Max M. Cantor, associate professor of Biochemistry at the University of Alberta, gave a very instructive lecture to the nursing students of that university on the role of chemistry in the advancement of medicine. This paper originally appeared in the Calgary Associate Clinic Historical Bulletin, Vol. 10, No. 1, May, 1945. We are indebted to the Bulletin for their courtesy in permitting us to bring this interesting material to a wider group of nurses.

Eleanor MacIntosh, science instructor in the School of Nursing of the University of Alberta Hospital, has contributed a very useful account of the newer values which have been discovered to exist in Coramine.

We have all learned some of the facts relating to the usefulness of herbs in the treatment of disease. Yet the specialist's knowledge which George H. Hamilton brings to the discussion will not only enliven our interest in such common garden plants as mint or garlic but will also serve to increase our store of information. Mr. Hamilton is botanist with the Niagara Parks Commission.

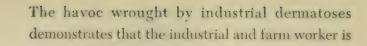
Why do girls choose nursing as a career? What has the profession to offer in the way of moral support to the nurses who are busily engrossed in their immediate job? Pauline Capelle, instructor in public health nursing at the University of British Columbia, answers some of these pertinent questions for us.

Jean MacTavish is keenly aware of the values of the out-patient department in the education of the student nurse. She gained her knowledge through her own observations while she was head nurse in this department at the Ottawa Civic Hospital.

Margaret McIntosh has given us an excellent description of poliomyelitis in addition to a detailed outline of how the health department of the city of Montreal enlisted public support in countering the 1946 epidemic. Miss McIntosh is a member of the health department staff and a representative on the executive of the Public Health Section of the A.N.P.O.

Continuing their study of personnel policies, the contributor to the Institutional Nursing Page this month, Sister Mary Beatrice, is superintendent of nurses at St. Joseph's Hospital, Glace Bay, N.S. The article is based on her personal experience there and also the administration experience she had at St. Michael's Hospital, Lethbridge.

Archibald Andrews, aged sixteen, was in hospital with a fractured femur when he sketched the cartoon. You will have heard the story before about how busy our doctors are!



"just as sensitive as an artist"

to chemical, mechanical, biologic, and plant irritants

Control of itching is singularly simple with Calmitol Ointment. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate, reduce the sensitivity of cutaneous receptors and nerve endings by raising their sensory threshold. Free from stimulating or keratolytic drugs and free from potentially harmful phenol or cocaine derivatives, Calmitol does not cause unwanted by-effects.

- L Checks itching, smarting and burning which interferes with concentration and acuity.
- 2. Minimizes danger of infection.
- **3.** Helps protect against further exposure and continued dermal injury.

CALMITOL

The Leeming Miles Co Ltd.

I NOTRE DAME ST. W., MONTREAL I, CANADA





In ancient Greece, the roots of the mandrake were regarded as a panacea.

To prevent townspeople from picking them, however, the men who made their living selling the root said the mandrake shrieked when uprooted—and that anyone who heard the weird sound fell dead!



Some folks believe that unless canned foods are thoroughly cooked they should not be served.

In the canning process foods are thoroughly cooked. All you need do is heat and season to taste.



A M E R I C A N C A N C O M P A N Y
KENTVILLE MONTREAL HAMILTON TORONTO WINNIPEG VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

-a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

CANNED FOOD IS GRAND FOOD

I	AMERICAN CAN COMPANY
ĺ	92 King Street East, Hamilton, Ont.
1	Please send me the new Canadian edition of "THE CANNED FOOD REFERENCE MANUAL," which is free.
1	Name
	Professional Title
	Address
	City Province

Vol. 43, No. 10

750



Ayout

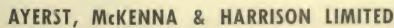


AYERST STREPTOMYCIN

Ayerst Streptomycin may now be obtained for your patients either from your hospital or your pharmacist.

Clinical experience has shown that this product is particularly effective against urinary tract infections, influenzal meningitis, tularaemia, bacteraemias, wounds and other infections caused by streptomycin-sensitive organisms.

Ayerst Streptomycin (No. 955) for parenteral use is supplied in vials of one Gram-



Biological and Pharmaceutical Chemists

MONTREAL CANADA

OCTOBER, 1947 751



"From Contented Cows"



Canadian Tampax Corporation Ltd., Brampton, Ontario.

ADDRESS PROV. ... P7-27

or external irritation⁵...does not expose the flux to odorous decomposition³...and cannot cause noticeable bulkiness. Its small size makes TAMPAX inconspicuous to carry and easy to store and dispose of.

Samples of the three absorbencies (Regular, Super and Junior) for individual requirements gladly forwarded on request,

REFERENCES: 1. West. J. Surg. Obst. & Gyn., 51:150, 1943. 2. Am. J. Obst. & Gyn., 46:259, 1943. 3. Chn. Med. & Surg., 46:327, 1939. 4. Am. J. Obst. & Gyn., 48:510, 1944. 5. J.A.M.A., 128:490, 1945,





OCTOBER, 1947

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to:

Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal Victoria Hospital, Montreal 2, P. O.

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

TORONTO HOSPITAL FOR TUBERCULOSIS

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$95 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses -

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

-One-Year Certificate Courses

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to: School for Graduate Nurses 1266 Pine Ave. W.

McGILL UNIVERSITY, MONTREAL 25

REGISTRATION OF NURSES

Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on November 19, 20, and 21.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

The Director,
Division of Nurses Registration
Parliament Buildings, Toronto 2



We value greatly the confidence which the medical profession has placed in Nestlé's Irradiated Milk. To continue to merit this confidence, we shall maintain our eighty-one year old policy of constant research and vigilant quality control.

Nestlé's Milk Products (Canada) Limited

METROPOLITAN BUILDING, TORONTO



OCTOBER, 1947 757



758 Vol. 43, No. 10



CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER TEN

MONTREAL, OCTOBER, 1947

expensival for the continuous continuous of the continuous continu

Ontario Seeks New Nursing Bill

It is well known that Ontario, the first province to seek nursing legislation, was the last to obtain it. The Nurse Registration Act was passed in 1922, and differed from the nursing acts of other provinces by placing the entire control of nursing, including the granting of registration, in the hands of a department of government.

The result of this legislation, which has received most attention, is that membership in the nursing association of Ontario is voluntary, and, therefore, does not include all nurses. Of course, the last word has not been said on the respective merits of voluntary enlistment and conscription; at least not in fields other than nursing. But the argument does become academic when licensing is granted by the association; and we are agreed that licensing is desirable. Ontario nurses have not been worried so much by the fact that their association did not issue registration certificates, as they have been that they do not control the preparation leading up to this registration; nor do they decide when it should be revoked. Even here, the situation is not so black as it has often

been painted. To advise him in the administration of the nursing act the Minister of Health has a Council of Nurse Education in which nurses predominate; and while this council is only advisory, it is influential. The Registered Nurses Association of Ontario is grateful to the Department of



NETTH D. FIDLER

Health for friendly relations and for much that has been accomplished for nursing in the twenty-five years that have elapsed since the passing of the

Nurse Registration Act.

However, when all is said and done, the nursing profession in Ontario is not self-governing; and the desire to be self-governing is surely both democratic and professional. The nurses of Ontario hold this desire strongly. It has been questioned by some whether the profession is mature enough for this responsibility. naturally claim that it is. At least its motives would seem to be. One of our avowed objects is the promotion of the public welfare. We have expressed our willingness to bring in European nurses, both on the ground of common humanity and because they are much needed here. Are we immature because we hesitate to assert that good nurses are produced only in Canada, and refuse to worry unduly over our personal "rights"?

But the public does not, I think, question our purpose and ethics. It is our education which does not meet the standards of other professions: and it is precisely in educational matters that we have least control and that our legislation is weakest. We do not control our educational standards, and in most provinces nursing education does not even benefit by the supervision of general education. There are now a fair number of nurses who have made the study of nursing and of nursing education their whole work; there are many others who have made it a major concern in their work in organized nursing. Even most of those nurses who are not primarily interested in education know the problems of nursing and the importance of

preparation to meet them. And we have no political problems to interfere. Surely nursing education is safer in such hands than in those of people without experience in either nursing or education.

The Bill, which the Registered Nurses Association of Ontario is asking the Minister of Health to bring in at the beginning of 1948, is framed to give to the profession control of education and practice in the whole field of nursing, professional and auxiliary. The educational control is considered to be the most fundamental The machinery for this (at present the Division of Nurse Registration) would remain essentially as it is at present, but the setting of standards would be by the profession. We are not greatly interested in filling in licenses, if this should mean merely rubber-stamping the products of a preparation which we have not approved. It is the preparation itself with which we are concerned.

We appreciate the things that have been done by the Department of Health, and we have co-operated fully with it; but we want to control our own affairs, and we feel that this would be to the public benefit. preparing our Bill, we have received many suggestions and much help from the nursing acts of the other provinces. We hope that when we have a new Act it also will prove helpful. As, after twenty-five years, we in Ontario try again for professional self-government, we know that we have the sympathy and support of our eight sister associations and of the

NETTIE D. FIDLER
President
Registered Nurses Association
of Ontario

Attention! McGill Graduates

To all the graduates of the School for Graduate Nurses, McGill University, Montreal:

Please address your Alumnae Association in care of its President, 1615 Cedar Avenue,

Montreal 25. Note that all cheques should be made out to the A.A., School for Graduate Nurses, McGill University, and include fifteen cents for bank exchange.

Thank you!

Chemical Research and Medical Progress

MAX M. CANTOR, B.Sc., M.D., F.A.C.P. (C)

THE NATURE OF MEDICAL PROGRESS IN THE STUDY of medical history. the historian is apt to take at face value the self-appraisal of the medical profession which too frequently conceives itself as a specialized and selfsufficient group. A cursory examination of medical progress reveals how unjustified such an assumption is. The nature and functions of medicine are circumscribed by other sciences and social institutions. Spontaneous creation can no more explain medical discovery than it can the origin of life, because medical discovery is a product of the intellectual, technical, scientific, and medical traditions which precede it. It is true that a few medical discoveries are epochmaking in that they are milestones which indicate new directions or paths for enquiry; but the road along these milestones, lined with contemporary advances in other sciences and in social changes, cannot be ignored in a realistic approach to medical history.

Emphasizing this dependence of medical discovery upon existing knowledge does not belittle the achievements of the men to whom these discoveries are usually attributed. There is no implication that their work is negligible and unimportant, nor denial that they devoted years of painstaking research to their investigations. But in medicine we are prone to attribute progress romantically and falsely to individual genius, rather than to the efforts of thousands of persons in the past and present. This type of mistaken judgment is seen in the characteristic comment by Warfield Longcope in Milestones in Medicine: "It is upon the individual working silently for years, unhampered, free of thought, usually unappreciated, that we must turn for the idea, the spark, the jewel upon which the wheel must turn." Robert Koch might fit into this description,

but it would take some imagination to make it conform to Paracelsus, Pasteur, Lister, John Hunter or a host of our other Greats.

The creative personality in medicine as in other sciences does not effect change by the mere exercise of a powerful will as most biographers suggest, but rather by synthesizing elements in his tradition into new forms, slightly different from those which preceded them. Thomas Hardy provides us with an excellent analogy to explain these sudden wonders: "A coral-reef which just comes short of the ocean surface is no more to the horizon, than if it had never been begun, and the finishing stroke is what often appears to create an event which has long been an accomplished thing." If we are to get beneath the surface of medical history, we must sound the depths of medical discoveries to see what intellectual currents left the deposits to make them possible. We must probe the nature of the seeds that flowered successfully and study the scientific soil and the climate of opinion that nurtured them. My purpose is to trace some of the streams of achievement that flow from the growth of chemistry.

THE FOUNDATION OF SCIENTIFIC CHEMISTRY

The art of chemistry was practised thousands of years before the Christian era: the science itself dates no further back than the 17th century. Alchemy, a transient phase in its development, reached its peak in the 15th and 16th centuries. The energy which alchemists devoted to the transmutation of metals and to the search for the Philosopher's Stone bore little fruit and deserves only passing mention. As it developed, however, and the number of chemical products increased, there arose a school of alchemists who sought to apply chemical principles for the

OCTOBER, 1947

clarification of vital phenomena. These men were physicians who believed that human illness resulted from abnormal chemical processes within the body. As such, they could be counteracted by appropriate chemical remedies. Iatro-chemistry, as the science was known, suffered a serious deformity in its birth, because the philosophy of its chief exponent, Paracelsus, was filled with mysticism, theosophy, pantheism, and astrology. It took two centuries and the guidance of worthier men to emancipate chemistry from alchemical slavery. From the iatro-chemists came one great step in medical progress. They insisted that the true function of chemistry was not to make gold, but to prepare medicines and substances useful to the arts. Chemistry thus became indispensable to medicine and was taught in the schools and universities as an essential part of medical education.

The foundation of scientific chemistry was laid in the 17th century when nearly every department of human knowledge was permeated by the spirit of enquiry and reform. This new experimentalist attitude of chemistry, based on observation and reason, experiment and conclusion, was founded by Robert Boyle. In his book, the Skeptical Chymist, published in 1661, he attacked the principles of the alchemists, gave the name and defined the basic concept of "chemical elements" as substances which could not further be divided by any known process, and insisted that the number of elements must be settled by experiment rather than by abstract reasoning. Physicians did not take kindly to this attitude at first. They would have been content with the romantic speculative alchemy which fitted nicely into their own scheme of things. The predominant judgment of the time is illustrated in the view of Leo Africanus that chemists "were a most stupid set of men who contaminate themselves with sulphur and other horrible stinks," and of Jonker, Stahl's disciple, that chemistry was of no use at all to medicine.

The significance of Boyle's ideas was not grasped until Lavoisier corroborated them late in the 18th century. Stahl's vitalistic theory of Phlogiston contributed considerably to this delay, particularly when important chemists such as Priestley held firmly to it. The effect of the Phlogiston theory in impeding chemical studies on medical processes is seen in the repeated assertions of leading physicians of the time to the effect that medicine could well do without chemistry. Even as late as 1855. Trousseau is quoted as saying, "When the chemist has seen the chemical conditions of respiration, of digestion or of the action of some drug, he thinks he has given the theory of those functions and phenomena. It is ever the same delusion which chemists will never get over. We must make up our minds to that, but let us beware trying to profit by the precious researches which they would probably never undertake if they were not stimulated by the ambition of explaining what is outside of their range." It was this traditional hostility to chemistry which formed the setting of the well-known medical opposition to Pasteur. Here was a chemist whom circumstance drove into pathology where he made his greatest contributions. His findings challenged the authority of physicians and placed him in the role of pariah.

While Black, Priestley and Lavoisier were studying the chemistry of gases, significant chemical researches in digestion were being carried out by Réaumur. The iatrochemists explained digestion as a process of fermentation. Réaumur sought to test this idea experimentally. He studied the enzymatic action of gastric juice outside the body and showed that there was an optimum temperature for its action. Spallanzani carried these observations further and showed that the solvent action of gastric juice was different from the processes of fermentation and putrefaction and laid the foundations for some of the modern analytical methods for investigating enzyme action.

CHEMISTRY IN THE NINETEENTH CENTURY

The nineteenth century saw the modernization of chemistry. Much effort was expended in differentiating ordinary materials. Attempts were made to analyze compounds, and certain irreducible elements postulated by Boyle came to be recognized. The results were formulated mathematically and a nomenclature was devised to designate them. Proust, Berthollet and Dalton produced evidence that elements combined in multiple and definite proportions. Gay-Lussac formulated the law of the combination of gases in 1808 and, in 1811, Avogadro proposed the principle that equal volumes of all gases contain an equal number of molecules. Dalton's formulation of the atomic theory prompted the Swedish chemist, Berzelius, to make an elaborate study of atomic and molecular weights, which he calculated for about two thousand substances. In the middle of the century, Mendeleev in Russia, and, independently, Mayer in Germany, announced the periodic law. This enabled chemists to predict the existence of chemical elements not vet identified.

One of the most significant contributions of chemistry to medicine came with the synthesis by Wöhler of urea in 1828. Until that time inorganic and organic substances were differentiated by the belief that while inorganic material might be prepared artificially, organic substances could only be formed as the result of vital force. Such substances as urea and uric acid were known and had been analyzed but it was thought that they could never be produced without the intervention of life in some form. This synthesis of urea, accomplished, as Wöhler wrote to Berzelius, "without the use of kidneys or animals for that matter," occupies a unique place in human thought. It demonstrated for the first time the possibility of synthesizing a substance elaborated by the organism. In the philosophy of the last century it had an effect comparable to "Darwin's theory of the

origin of the species and Pasteur's demonstration of the parasitic origin of pestilence." It shattered the entire vitalistic conception and laid the foundation for the extraordinary developments in synthetic chemistry which have proven so epoch-making for medicine as well as for chemistry.

The chemical manipulation of the compounds of carbon, the field of work covered by the organic chemist, has led to the synthetic preparation of thousands of drugs. New ones are being added constantly. Among these the discovery of anesthesia stands out as a milestone which has been more conducive to the progress of medical sciences than has any other single development. Our knowledge of the mode of action of the individual organs and the body as a whole, in health and in disease, is due in the greatest measure to the discovery of anesthesia. Without it, physiology, biochemistry, pharmacology, pathology, and bacteriology would have remained for the most part barren speculative disciplines. Rival claims could not have been examined critically, for data could not be collected to decide for or against a given hypothesis, because of the torture which would prevent all but a very few from investigating the problem. Apart from this contribution to experimental medical science, it made surgery an art, technically easier and personally more agreeable. It spared the patient untold misery and anguish. reduced the operative risk, and hastened recovery. Modern surgery rests as much on anesthesia as it does on asepsis, and chemistry provides the agents on which both rest.

Modern Chemical Advances

The vast majority of the drugs produced by the organic chemist serve for the symptomatic relief of pain and insomnia. Their numbers are manifold and new ones are added at a rate which makes it almost impossible to keep pace with their development in one field alone. The application of these for the prevention and relief of distress needs no elaboration. The development and

growing importance of the highly specialized branch of chemistry which is concerned with the production of synthetic hypnotics provides an inspiring tale of scientific achievement, in which chemists and pharmacologists work in close collaboration to produce drugs which provide the maximum of hypnosis with the minimum of toxicity and habituation. From such investigations has arisen an entirely new science—that dealing with the relationship between chemical composition and physiological action. The application of this new knowledge cannot help but guide chemical therapeutics along sane channels. In the field of specifics, only one remedy has been produced so far. This was Salvarsan, Ehrlich's remedy for syphilis. Germanin, or Bayer 205, used in the treatment of African Sleeping Sickness may be another. The introduction of the sulfa group of drugs, which might also be placed in this class, has greatly influenced the course of many bacterial diseases. A new relative of this class, promin, holds forth some promise in the treatment of acute tuberculosis. One might also place the antibiotics in the category of specific drugs. Developments in this field are of such recent date that no recounting seems necessary. now have two of these, penicillin and gramicidin, produced in such quantity as to be readily available for general use. A third member, streptomycin, bids fair to assist materially in the treatment of the white plague, tuberculosis.

Progress in these fields has been at such a pace that it has seemed to overshadow contemporary chemical research in other fields of medical interest. It comes as a surprise, therefore, to learn that Goebel has been successful in the production of synthetic antisera for types II, III and IV pneumonia. This opens a new and hitherto undreamed-of field in immunotherapeutics.

In immunochemistry we have an illustration in which medical science contributed to the development of a new field in chemistry. The original reactions of immunity were outlined

to solve urgent problems relating to disease. The chemical significance of the reactions of immunity were not appreciated since they dealt with such complex mixtures of unknown constitution as bacteria, cells and serum that any chemical consideration was impossible. Then, too, Ehrlich's presentation, while pictorically satisfying, had no chemical significance. Even when Bordet pointed out the close similarity of the reactions of immunity to those of colloid chemistry. investigators remained unimpressed since they lacked the knowledge of the colloid chemists' point of attack. With the increasing availability of pure proteins to replace such complex materials as bacteria and cells in the study of immune reactions, the immunochemist and the immunologist, working in co-operation, can be expected to clarify many of the complex problems of both biological and colloid chemistry. One cannot help but feel that future developments in this field will lead to methods of protection against many diseases by the use of synthetic chemicals rather than by recourse to vaccines and immune sera. With improving knowledge the scope of chemotherapy in this field may be expected to widen.

CHEMICAL RESEARCH AND MALIGNANT DISEASE

Chemistry has not only invaded the field of bacterial diseases but is making outstanding contributions in the elucidation of malignant processes. Up to the end of the last century, cancer research was confined to descriptive observations on cancer in man. Isolated reports of cancer in other mammals were ignored. Keen observers from time to time called attention to the association of cancer with certain occupations but speculation as to etiology provided no special clues. A remarkable exception was the keen observation of Percival Pott who in 1775 recognized the possible relationship of cancer of the scrotum in chimney sweeps and coal soot. Gradually there developed a knowledge that certain occupations carried a definite cancer hazard for those engaged in them. This list has grown to considerable proportions. Promising leads for the study of cancer became available but their importance was minimized when Virchow focused the attention of investigators on the tissue cells which were supposed to undergo malignant transformation as a result of chronic irritation. The cell theory, later modified to attribute cancer to embryonic cell rests or to abnormal regeneration of injured tissues, further confused the issue.

More confusion came with the firm establishment of the parasitic nature of disease; and search for a specific infectious agent which caused cancer was instituted. This search is still being continued to some extent. Each of these attempts to explain the etiology of cancer had the weakness of over-simplicity. Real understanding did not come until the end of the 19th century when Claude Bernard's plea for controlled experimentation was heeded and applied to the problem. When experimental production of cancer in animals was first demonstrated by Yamigawa and Ichikawa in 1915, the trend of cancer research was, shifted into the field of chemistry. In the fifteen years which followed, seven hundred papers dealing with the production of tumors by tar and tar products appeared in the literature. The great revival of interest in the etiologic factors was the direct effect of the brilliant researches upon the chemistry of the coal tars. Kennaway, who had worked for several years on crude pitches, oils and tars, concluded that the carcinogenic principle must be in the unknown compounds in the coal tar. While several hundred such compounds had been identified, only about one hundred had been isolated. Thus the chance of selecting the proper agent seemed well-nigh impossible. When Mayneard applied fluorescent spectroscopy to this problem, Kennaway's group were quick to notice the resemblance of the fluorescent spectrum of benzanthracene and one of their carcinogenic fractions from coal tar. The alert, prepared mind was thus ready to test the use of a purified chemical substance in the production of cancer. When positive results were obtained, it became just a matter of time until they were able to identify and isolate 3, 4 benzpyrene from the coal tar. Further investigation showed that the phenanthrene ring was common to all the carcinogenic compounds and it was pointed out that such a structure is present in many biological substances. At the present time about two hundred and fifty synthetic chemicals having carcinogenic properties are known.

The ease with which chemical carcinogenesis is produced has served to elucidate many problems in tumor histogenesis. It has been shown, for example, that tissue injury need not necessarily precede tumor formation so that the term chronic irritation is no longer completely tenable. Research in chemical carcinogenesis has shifted the attention away from a search for structural changes and toward changes within the cell, from histopathology to cell biochemistry. The intracellular chemical changes which occur coincident with malignant change are now receiving major attention in many laboratories. The information which will accrue from these investigations promises to throw much light on cause and nature of malignant change. Already our ideas with regard to specificity have been altered. Thus methyl cholanthrene can produce malignant change in a great variety of tissues by producing permanent alterations in the cell physiology. The transmission of this alteration in intracellular physiology to all the descendants—a form of mutation—is still not clearly explained. There is evidence accumulating that this change can be produced in tissue cultures suggesting that carcinogenesis is the result of direct interaction between carcinogen and cell and has no dependence upon favorable systemic conditions.

Stanley's separation of a crystalline protein substance from the tobacco mosaic virus disease and Shope's more recent isolation of the rabbit papilloma virus which goes by his name may be the beginning of the

explanation. These proteins have the power to promote growth in tissues and are extractable from the processes which they have produced.

One of the most interesting developments in this field touches on the relationship between chemicals which are carcinogenic and some of the important dietary constituents such as cysteine and biotin and riboflavin. I recognize the danger of prophecy in this field, but cannot refrain from voicing the belief that this new lead will provide us with an entirely new concept regarding the etiology of cancer. Whether it will also provide us with a new method of therapy is beyond my prophetic power.

CHEMISTRY AND MEDICAL DIAGNOSIS Chemistry provided not only new drugs but made possible great strides in medical diagnosis. Successful diagnosis depends to a large extent on the physician's ability to assemble and evaluate the evidence of disease. The history, the physical examination, and the laboratory investigation form an important triad in modern diag-While it is true that most nosis. diagnoses may be achieved by a careful analysis of the history and prolonged and repeated physical examination, the interests of the patient are better met by carrying out in addition some laboratory procedures to test the chemical efficiency of the patient's organism. The steps which led to the development of chemical function tests are rather difficult to trace. The debt which medical progress owes to them has never been fully appreciated by the profession at large. Banting and his associates would not have isolated insulin so readily had they not had at their service a rapid chemical method by which the blood sugar could be estimated without sacrificing an animal for each test and waiting forty-eight hours for each report. Collip would have had great difficulty in obtaining parathormone if a simple accurate method for the estimation of calcium had not been elaborated first.

I have no intention of dealing with every chemical process related to dis-

ease. I do wish to choose one example to indicate how closely chemistry touches the problem of life and disease. Renal disturbances have been among the most baffling problems in medicine. It is only in recent years that, aided by chemical research and effort, rapid progress has been made. It is true that a real understanding of disease is dependent on an accurate knowledge of the mechanisms involved. It is equally true that efficient methods of combatting disturbances depend on a clear conception of the actual changes which have taken place and the cause of these changes. It took three centuries of continuous investigation to provide us with our modern ideas regarding the complex structure of the kidney. How the kidneys perform their work, while still partly unsettled, has been determined by studies directed along chemical lines. Anatomic and pathologic investigation formed the groundwork upon which chemical research into kidney function has been based.

The excretion of water, the elimination of salts and metabolites, the maintenance of acid-base equilibrium are all fine discriminating functions of the kidney which have been elucidated by studies fundamentally chemical in nature. Accurate quantitative determinations of excreted products are dependent upon the development of methods of quantitative chemical analysis. Studies dealing with the method by which the kidneys assist in controlling acid-base balance in the body depend on the use of sensitive indicator dyes. The introduction of such dves into the living kidney made possible accurate studies of the part played by different structural elements in this important activity. Our knowledge of the mechanism of urine secretion we owe to the rapid development of that phase of physical chemistry which deals with the laws of membranes and surfaces, of filtration and osmotic equilibrium. These new methods of analysis and synthesis, new facts and basic physical laws, and new conceptions and theories, are all necessary for the final solution of the problem.

CHEMISTRY AND NEW CONCEPTS OF DISEASE

Chemistry not only provided us with new drugs and with methods of diagnosis, but also made possible new concepts of disease, such as glandular dysfunction and dietary deficiency. More than one hundred years ago, Berzelius advanced the idea that life phenomena were dependent upon the play of catalysts comparable to but different from mineral catalysts, the importance of which was already established at the time. Years passed without verification of his theory, but within the last twenty-five years, and more especially in the last few years, there have been discovered substances which play an important role in directing and controlling the development of living cells. Many of these vitamins and hormones have been isolated and produced synthetically by organic chemists. Before the chemists took up the challenge in these fields much of the work was of the "washtub variety." So intense was their application to the problem that in some instances they were able to present the structural formula of a substance and prepare a synthetic one before the natural one was isolated in pure form. They were even able to produce synthetic materials which have greater biologic activity than the corresponding natural ones whose activity they also enhanced.

The application of vitamins and hormones has yielded phenomenal results in the treatment of diseases of metabolism and nutrition. For this reason it is worth recalling that, prior to the present century, the concept of disease as a result of the lack of specific substances either in the diet or as a result of endocrine dysfunction was entirely outside of medical theory. The knowledge available did not make such a theory plausible. Diseases had been generally associated with positive agents, such as noxious vapors, toxic substances, infectious and parasitic agents. It was thought that there was but one kind of nutriment, termed "aliment," dissolved out of ingested food by the action of digestive juices. The term "protein" was not coined until 1839. Ignorance of the endocrine glands was so great that they were generally regarded as functionless

vestigeal structures.

As in the treatment of other diseases, many empirical anticipations were made in the field of cures, the reasons for the success of which were unknown. Hippocrates treated night blindness with a decoction of liver, Cartier cured scurvy with the leaves and bark of the fir tree, and Lind prescribed lemon juice for the British navy. Seaweed and sea sponges were used effectively in the treatment of goitre centuries before the discovery of iodine. It is only within recent years that chemistry enabled medical science to solve the mystery of these cures.

The experience of medicine in discovering the cause of and cure for the nutritional and endocrine disorders is of such recent date that a recounting at this time seems unnecessary, except to point out that the phenomenal advances in this field are only part of the much larger pattern of advance in the study of general metabolism — study made possible by chemical progress in purification of biological substances and in methods of experimental biologic research. It may be safely assumed that pure chemistry has just about accomplished its task both in hormones and in vitamins. Biochemists and physiologists have pretty well determined the physiological function of these mate-The last and final step, that dealing with the mechanism of their action, is now receiving major attention from those versed in the methods of intracellular chemistry.

THE INTER-RELATION OF CHEMISTRY AND MEDICINE

Other influences of recent chemical research upon medicine are so numerous that to recount them would require a survey of the entire field of medicine. The medical man is dependent upon chemistry for his reagents, for aniline dyes and vital stains, for preservatives and for the principle of specificity which is at the basis of immunology and serology.

Biophysics and biochemistry contributed the potentiometer and buffer solutions for measuring hydrogen ion concentration, the measure of vitality and metabolism, the technique for the measurement of osmotic pressure. and the accumulating data of colloid chemistry and crystallography in all its phases. Andral followed the examples of chemistry when he started to weigh fibrin and corpuscles and blood serum, and lately the significant developments in blood chemistry have transformed diagnostic procedures. The work of the chemist on the structure and chemistry of the sugars and on amino-acids established the basis for the work on carbohydrate and protein metabolism. Progress in chemistry affects progress in medical research. This is illustrated by the studies which followed Urey's separation of hydrogen isotopes. Deuterium (one of the heavy hydrogens) has been used experimentally as a chemical tracer in studying fat metabolism in animals, opening up in this way a vast new field that may contribute considerably to human physiology.

Specialism and Research

Medical scientists tend to set up a barrier which divides their knowledge from the rest of organized knowledge. The same is true of other sciences which set up arbitrary fences to keep their areas of influences separate. Bordering these dividing lines are zones little explored by the average scientist, since they appear a little too close to the territory of a science across the border. Yet the frontiers of every science are advancing until what was once well within the boundaries of one science is now the frontier of a specialty. Thus chemistry and physics encroached on each other's territory to the extent that physical chemistry was born. Physiological chemistry gave birth to biological chemistry and biophysical chemistry, to phytochemistry, to clinical chemistry, to psycho-biochemistry and so on. Each one of these specialties confines a field of knowledge sufficiently extensive to know much within it and little outside of it. The orthodox research worker limits his studies to problems well within the border. The uncertain frontier areas are studiously avoided. In this way the zones of knowledge bordering on the specialties have become an intellectual no-man's land.

Pioneer investigators have learned that the less-known territories along the frontiers of the specialties offer a fertile field for research. To equip themselves for exploring these areas they have trained themselves in more than one science. They are heedless as to whether they are classified as physicists or chemists or clinical chemists or chemical pathologists. The late Jaques Loeb was an excellent example, for when he was asked whether he was a physicist or chemist, he replied, "I am a student of problems." The primary concern of such a scientist is with the problem in which he is doing research. If it leads him across the border, so much the better, for the frontier holds opportunities for discovery. Specialized research has piled up multitudinous data and today there is need for correlating this information.

It has been said that medicine today needs frontiersmen-men who, from a knowledge of more than one branch of learning, can look across the border, find new meaning for the facts already discovered there, and work in co-operation with those who have long specialized in that field. Dr. Oliver Wendell Holmes said, "The recording of facts is one of the tasks of science, one of the steps toward the truth, but it is not the whole of science. There are one-storey intellects, two-storey intellects and three-storey intellects with skylights. All fact-collectors, who have no aim beyond their facts, are one-storey Two-storey men compare, men. reason, generalize, using the labors of the fact-collectors as well as their own. Three-storey men idealize, imagine, predict: their best illumination comes from the above, through the skylight."

Some Medicinal Plants

GEORGE H. HAMILTON, B.A., M.Sc.

N 1938, the Niagara Parks Commission had a small herb garden constructed at the School for Apprentice Gardeners. While the war years inhibited the full development of this project, the small collection of herbs contained therein has attracted considerable attention. Visitors are always keenly interested in these plants, especially those which have some medicinal use. It should be noted, however, that all herbs are not used medicinally, because a true herb, by definition, is any plant which possesses some value for flavor. fragrance, or medicine. Nevertheless, experience has shown that it is the species which have been or are used to alleviate or cure man's ills that capture the interest and imagination.

HISTORY

How did man discover that some plants possessed properties that would relieve his physical pain and assist him in his recovery from illness? No one knows. It is a story which has its origin in his clouded antiquity and there can be no doubt that the method of trial and error permitted him to arrive at certain conclusions regarding the efficaciousness of certain plants in treating disease. Who can measure the mental anguish of the cave-man parent who, unable to bear the sorrowful cries of his suffering child, in his desperation rushed to the nearby jungle and grasped the first plant at hand with the hope that a poultice or infusion would offer some relief? No doubt, from experiences such as this, he learned to recognize that certain plants had medicinal properties. This knowledge passed on from generation to generation by word of mouth made up the pharmacopeia of man for thousands of years.

Because this method of learning was so slow, the remedies so few, and the suffering so great, it is no wonder that superstition for many years played an increasing part in his treatment of disease. We laugh at some of the ridiculous remedies that prevailed just a few hundred years ago, yet an understanding of the dilemma of the physician of that period reveals only the tragedy of ignorance.

It is not so long ago that the "Doctrine of Signatures" was accepted. This theory sprang from the belief that God had placed a sign on most plants to indicate their usefulness to man. Thus, species with heart-shaped leaves indicated some property which would cure heart ailments; while kidney-shaped leaves were beneficial for kidney conditions, etc. While this doctrine was held for many years, "the proof of the pudding is in the eating," and the results have finally given it the coup de grâce.

By the beginning of the twentieth century, herbs had fallen into such disrepute that herb gardens were regarded as, at best, a carry-over



Rue

OCTOBER, 1947



Lavender

from the past. In the eighteenth century, every household devoted a part of the kitchen garden to growing herbs. Now there are practically none. What is the true picture of present-day appreciation of medicinal plants? While I can only give a layman's opinion, I believe that it may be stated as follows:

The medical practitioner: The doctor



Horehound

still makes use of a number of plant products in the treatment of disease. No longer does he grow or gather his own plants, but depends upon drughouses for the manufacture of preparations which are pure and of a stated concentration. An examination of the pharmacopeiae of modern medicine reveals that the number of plant products in use in medicine is gradually decreasing, because of the discovery of more effective substitutes or, especially, through the synthesis of the valuable plant principle in a pure form. Nevertheless, he still depends on certain plant drugs and will continue to do so until more powerful or effective means of treatment are discovered. This does not in any way lessen his obligation to medicinal plants, nor should he despise this gift of nature. Most conspicuous in recent years has been the realization that often amidst the queer concoctions of the medicine man of the past there lies some valuable principle that is worth rediscovery, i.e., curare.

The average man: Through education by way of the press, radio, and other means, the average man recognizes the value of the scientific approach and for this reason, for the most part, accepts the treatment of the modern physician. Yet it is sometimes disquieting to note how tenaciously some people in rural areas cling to the ancient beliefs. For instance, it is reported that several deaths occur each vear through the use of "Tansy tea" as a spring tonic. How many people believe in the use of the hackberry to restore youth and virility? Sometimes, by way of conversation, it might be interesting to note how many of these ancient remedies are still held in high regard—so much so that I have decided to pass a few of these ideas along, in order that you may not be too strongly influenced when you encounter them. There is one important psychological fact which should not be overlooked if the patient has sufficient faith in these things, then I can see no

harm, in fact much good, in permitting

him to indulge in such treatment.

MEDICINAL PLANTS — FACT AND FANCY

For your interest, I have selected certain herbs, around which interesting legends have been woven, which still are held in respect in some parts of Canada:

DILL (Anethum graveolens): A plant much to be feared because magicians and those people who possess the power to cast spells use this plant in making charms. In some parts of Europe, no bride would carry her bouquet without including a sprig of dill to ward off ill-luck.

WORMWOOD (Artemisia absinthium): It is used in France to make absinth liqueur, which once was almost a national drink. It has recently fallen into disrepute because it was found that habitual use tended to induce nervousness and depression. The ancient Romans believed strongly in its aphrodisiac powers, and even in more modern times the belief was held that if a maiden placed a sprig beneath her pillow at night or carried it behind her back she would marry the first man she met in the morning (unattached internes, beware!).

CARAWAY (Carum, carvi): In ancient times, it was thought that eating the seed promoted a good complexion and Dioscorides prescribed it for pale-faced girls.

FENNEL (Foeniculum dulce): Many of our local Italians grow fennel for its fine flavor. It is often held that it has the power to strengthen sight.

LAVENDER (Lavendula vera): Besides its ancient and modern use as a perfume, lavender should be used by all women because, according to legend, it has great power "to protect women from being beaten by their husbands."

PARSLEY (Petroselinum sativum): Besides its modern medicinal and culinary uses, parsley has an important place in legend. Just recently a visitor to the herb garden informed me that parsley has great power to prevent inebriation. This belief goes back to ancient Roman times when it was customary to wear chaplets of parsley to absorb the fumes of wine and thus delay drunkenness. (It would not be in good taste to visit friends carrying a sprig of parsley!).

ANISE (Pimpinella anisum): Pliny stated that if it is suspended in the bedroom it will prevent nightmares and promote



Tarragon

a youthful look.

RUB (Ruta graveolens): It is recorded that the odor of this plant is repulsive to most people, but some, it is said, are enthusiastic about its fragrance. I have yet to discover anyone who finds its scent or flavor agreeable. In fact, all are unanimous in stating that its smell is mildly nauseating. Yet, it is recorded that one of the ancient kings believed that it was an antidote to poisoning and would



Absinth



Spearmint

promote longevity, so ate some each day. One writer adds the comment that the king must have been very fond of life indeed.

SAGE (Salvia officinalis): The name of this plant suggests its early use to promote wisdom and memory. In some parts of the world it is said that when it grows well in a garden it is a sign that the woman is the ruler of the household.

TANSY (Tanacetum vulgare): First used in America as a preservative for the dead, later as an insect repellent for meats. It contains a virulent poison and should not be used internally.

It should not be thought that herbs are useless, but many have proven qualities worth knowing. The accompanying table gives the properties of some of the medicinal herbs grown at the Niagara Parks Commission's School for Apprentice Gardeners.

Common Name	Botanical Name	Part Used	Medicinal Properties
White Bedstraw	Galium mollugo	Stem and leaf	Decoction for a soothing foot bath.
Bergamot	Monarda fistulosa	Whole herb	Stimulant, carminative, rubefacient.
Boneset	Eupatorium purpureum	Leaf and flowering top	
Borage	Borago officinalis	Leaf	arrh and feverish colds. Gentle laxative, in cat- arrh, rheumatism, skin diseases.
Bugloss	Echium vulgare	Root	Astringent, blood puri-
Butterfly Weed	Asclepias tuberosa	Root	fier. Emetic, used in bron- chitis, rheumatism, in-
Catnip	Nepeta cataria	Leaf	duces perspiration. In hot infusions as a sedative, and for feverish colds.
Foxglove	Digitalis purpurea	Leaf	Heart disease, dropsy, a narcotic, sedative, stimulant.
Garlic	Allium sativum	Bulb	Expectorant, rubifacient, diaphoretic in bronchitis, coughs, and colds. Antiseptic much used in war, the expressed juice diluted with water and applied with swabs of sterilized cotton to bring out boils and ulcers.

Common Name	Botanical Name	Part Used	Medicinal Properties
Horehound	Marrubium vulgare	Leafy top	An infusion for bron chitis, coughs, colds, i lozenges and candy, i
Hyssop	Hyssopus officinalis	Leafy top	jaundice and dyspepsia In dyspepsia, coughs and colds, a cathartic induces perspiration.
Larkspur	Delphinium ajacis	Seed	(Poisonous) in asthma
Lavender	Lavendula vera	Flower	Spirit of lavender use as a stimulant and car minative when dilute
			and sweetened, oil rub bed on skin for ticks, a nervine and antisepti to swab wounds.
Lily-of-the- valley	Convallaria majalis	Root	As a heart stimulant cardiac dropsy.
Mint	Mentha citrata	Leafy top	Infusion to produce per spiration, relief of nerv ous headaches.
Mugwort	Artemisia vulgaris	Whole herb	Epilepsy, tapeworm.
Mullien	Verbascum thapsus	Leaf	In cigarettes as a relie for asthma.
Parsley	Petroselinum hortense	Seed and root	To dispel fever, for kidney trouble.
Pimpernel	Anagallis arvensis	Whole herb	To produce perspiration expectorant, nervine.
Рорру	Papaver somniferum	Seed pod	Juice is source of mo phine.
Rose	Rosa	Flower	Astringent, eye lotions
Rue	Ruta graveolens	Leaf	For worms, hysteria ar colic; juice as disinfe tant; bruised leaves for rheumatism, headache
Sage	Salvia officinalis	Leaf	Gargle, astringent, vu nerary, nasal sores, e pectorant, produces pe spiration.
Snakeroot	Cimicufuga racemosa	Root	Sedative, expectoran produces perspiration in rheumatism, fever asthma, dropsy, St. V
Tarragon Thyme	Artemisia dracunculus Thymus vulgare	Leaf Leaf	scurvy Sedative, in bronchiti whooping cough, inc gestion, flatulence ar
Wormwood	Artemisia absinthium	Leafy top	coughs. In fevers and rheum tism, anthelmintic, st machic, antiseptic, (al

Coramine - A Life Saver

ELEANOR MACINTOSH

Since coramine or nikethamide became available approximately fifteen years ago, thousands of scientists and clinicians have explored the possibilities of using, in certain well-defined emergencies, dosages of coramine higher than had originally been recommended. The results have been dramatic in that recovery has been achieved in desperate cases where all other therapeutic measures have failed. It, therefore, behooves us as nurses to become more familiar with the emergency uses of a "wonder" drug of such heroic value.

By chemical composition, coramine is known as a 25% aqueous solution of pyridine—B—carboxylic acid, and is of synthetic origin. This is just one of its numerous confusing chemical names, a few of which are as follows: Diethylamide of pyridine Z (B) carboxylic acid, diethylamide of nicotinic acid and N-N—diethyl nicotinamide. These names indicate coramine's close relationship to nicotinic acid. To make it more complicated for those of us not skilled in organic chemical formulae coramine is C_sH₄N.

CON (C₂H₅)₂. Despite these lengthy and complicated names, the pharmacology and administration of coramine are comparatively simple and toxicity is at a minimum. Any toxicity reported indicates that the higher motor centres may be stimulated by toxic doses. Experimental dosage in animals has been tried up to ten times the therapeutic dose before resulting in convulsions. Respiratory failure due to excessive stimulation of the respiratory centre would cause death. Since it is only in an emergency capacity that this drug is given in excessively large doses, the respiratory centre is in a state of depression at this time. It has been discovered that in these instances the toxicity is so low that the nurse need not have any fear about the large and repeated doses she may be called upon to administer. Small doses of 1.7 cc. or 5 cc. by subcutaneous and intramuscular injections are sometimes ordered in acute emergencies, but this dosage has recently been increased so that 5-15 cc. may be given intravenously and, in addition, 5 cc. introduced intramuscularly. If necessary, these doses are repeated after ten or fifteen minutes and again after fifteen or thirty minutes. Doses larger than 3 cc. require slow administration and careful watching of the patient, but it is suggested in these cases of extreme emergency that it is often the last cc. which saves the patient.

The absorption occurs in 15 to 30 minutes when given subcutaneously or intramuscularly, and effects are noted within a few minutes if given intravenously. Experiments on animals as well as recent clinical reports indicate that the chief action is on the central nervous system with direct stimulation of the depressed respiratory centre thereby improving respiration. This powerful effect on respirations leads to improved circulation, with increased oxygenation of blood and improved filling of the right heart cavities thereby relieving paroxysmal cardiac dyspnea in patients with cardiac failure who are both cyanosed and dyspneic. (According to the N.N.R. for 1946 this is no reason for use in chronic myocarditis, coronary thrombosis, coronary sclerosis or angina pectoris.) In cases of acute circulatory failure occurring in pneumonia or surgery as an emergency, peripheral vasoconstriction is increased and seems to be of benefit.

From available clinical reports, it is observed that the high doses of coramine produce striking therapeutic results in respiratory crises of morphine, barbiturate, paraldehyde, alcohol, lysol, carbon monoxide, and mushroom poisoning. Similarly, its analeptic action makes it useful in interrupting or controlling the depth and duration of basal anesthesia with

avertin. In these cases, coramine not only stimulates respiration but decreases narcosis by stimulating the cerebrum. As a rough rule for guidance, it is suggested that a patient who is stuporous but can be aroused will require about 5 cc. intravenously to fully awaken. If the patient is unconscious and respirations are shallow, either 5 or 10 cc. intravenously and 5 cc. intramuscularly, with the latter repeated in half an hour, will usually be adequate to awaken him. If the patient is even more depressed with reflexes absent and respirations irregular and failing, still larger doses must be given-either 10 to 15 cc. intravenously at once, or by repeating smaller doses at very short intervals. Since coramine possesses some depressant action in very large doses when using this drug it is important to try to make respirations adequate to carry patient through the dangerous phase of his depression, rather than to aim at achieving and maintaining respirations of normal rate, rhythm, and depth. A patient treated within fourteen hours of poisoning with any of the above drugs has an 80 per cent chance of recovery provided sufficiently large doses of coramine are used. If more than fourteen hours have elapsed the recovery chances are 50 per cent. In the latter condition, the patient may be saved by giving 100 to 120 cc. in 12 to 24 hours.

Other dramatic recoveries are reported in collapse following electric shock and stings or bites by animals carrying venom such as might follow an attack by a swarm of bees. cases of drowning, coramine has proven so successful that it is a "must" for emergency kits at beaches and swimming-pools. In instances of prolonged anesthesia, coramine has been used, its value lying in the fact that it changes the deep unconsciousness of surgical anesthesia into light sleep while the pain sensations continue to remain absent. In this way, aspiration pneumonia has been prevented. The treatment of asphyxia of the new-born does not require large doses of coramine in the usual sense of the word; but, considering the weight of the infant, the 1 or 2 cc. administered are very large doses indeed. In these cases the injection is made into the umbilical vein about four to five inches from the umbilicus and the injection is stopped with the first gasp.

It is hoped that the future of coramine therapy will remain a bright one, and that there will be other possibilities of similar spectacular results such as in the treatment of the respiratory failure of the dread disease of epidemic poliomyelitis. At present the reports indicate that this failure may be prevented by sufficient doses of coramine repeated regularly at the beginning of the disease. With this heartening outlook in mind, we look ahead to the future, confident that patient research and clinical investigation will bear further fruit.

BIBLIOGRAPHY

- 1. Bower, J. Louis. Coramine. Northwest Medicine. Seattle. Vol. 35. Mar. 1936. p. 89.
- 2. Blumgarten, A. S. Textbook of Materia Medica, Pharmacology and Therapeutics. 7th Ed. p. 339.
- 3. Ciba Company. Coramine in High Doses. Montreal.
- Goodman and Gilman. Pharmacological Basis of Therapeutics. The Macmillan Company. 1941. p. 270.
- Heard, Kenneth M. Coramine. Bulletin of the Academy of Medicine. Toronto. Aug. 1937.
- 6. Henderson, V. E. On Some of the Newer Drugs. Canadian Medical Association Journal. 35, 1936. pp. 636-637.
- New and Nonofficial Remedies. 1946.
 347.
- 8. Resuscitation of the New Born. Proceedings of the St. Michael's Hospital Clinical Society, Toronto. Vol. 1, No. 8. Dec. 2, 1938.
- Wright and Montag. Textbook of Materia Medica, Pharmacology and Therapeutics. 3rd Ed. p. 237.

The implementation of the Saskatchewan Hospital Act on January 1, 1947, provides public ward accommodation to all persons resident six months in the province on the payment of a fee of \$5 a year, with a family maximum of \$30.

The O.P.D. as a Teaching Field

JEAN MACTAVISH

THE OUT-PATIENT Department provides a fine opportunity for the student nurse to learn, if she is willing to avail herself of every chance that This department acts as a kind of "feeder" to the hospital, in that it provides examinations and treatments for many patients whose illnesses are not severe enough to necessitate hospitalization. conditions are seen in the O.P.D. clinics which are seldom, if ever, seen on the ward in the hospital. The Outdoor should be a well-organized department, offering an active service in all branches such as medicine, surgery, pediatrics, gynecology and obstetrics, dermatology, etc. The importance of sociological conditions, in respect to various maladies, is also of interest and should be studied by the students.

Advanced students should be assigned to this service if they are to participate effectively in the program, both from the point of view of the community and the educational opportunities which the service offers. They should be able to utilize all the knowledge and skills they have acquired up to this time.

An ideal situation would be one in which the supervisor or head nurse could spend enough time with each student to teach her the preparation, assistance, and administration of the clinic, as well as the social aspect, and to teach them thoroughly. A nurse with executive and teaching ability and, if possible, special training in public health, and with a keen sense of the social and economic need of the patients, would be most suitable for this position.

In order that the student may derive the most benefit from her experience in the clinic, it is essential that there be a co-operative clinical staff. If the staff doctor thinks the student nurse is really anxious to learn, he will be much more interested in demonstrating unusual procedures and explaining unusual conditions which may arise. Another service the O.P.D. offers is the preventive program—administration of toxoids, anti-toxins, etc. The student, may observe reactions and untoward effects that may take place. These are seldom seen on the ward.

It is essential above all for the student to remember that her patients are people with definite social responsibilities. A nurse may be able to do a treatment well, keep her ward in good order, or plan her work efficiently, but if she fails to show a sympathetic interest or understanding she is lacking in one of the greatest aspects she should offer in professional service.

A capable nurse is most essential in the smooth running of an outdoor department. It is all very well to tell a patient to follow a certain treatment or diet, but to make sure it will be carried out is another question. An illustration of this is seen in the supervision of the diabetic patient. He has to be taught the technique of administering his doses of insulin. He also must have an elementary grounding in the matters relating to his diet. In the interests of his own health, the student nurse might expect him to be concerned with all of the details. She must realize that the patient does not necessarily understand simply because she has told him what to do. The supervisor should check the student's teaching and show her how to strengthen it where necessary. In many cases a worker from the clinic will follow up these patients in their homes and help them with any problems which may come up. If the student is allowed to accompany the nurse on these home visits, she will learn to appreciate the patients as human beings. Patients who come into hospital are often under a certain tension and are not their normal selves. At the clinic and in their homes, the student can often assist

in discovering the true causes or relative causes of their troubles.

The opportunity to observe and recognize various pathological conditions in their early stages is provided in the outdoor department. A nurse needs to know how to recognize various diseases in the early stages, when the development may be arrested more readily and serious complications prevented.

As far as possible, all clinic teaching should be correlated with existing hospital services—e.g., prenatal care should be correlated with the inpatient obstetrical service. Thus the experience in obstetrics should, if possible, include a definite number of hours in the prenatal clinic, making

contacts with patients who will be hospitalized during the student's obstetrical ward assignment.

The pediatric clinic gives the student an opportunity to observe normal children and to teach child hygiene to mothers. Home care of children may be further expanded through follow-up of those who have been

hospital patients.

Altogether, the O.P.D. can prove to be one of the most beneficial departments to the student nurse from the standpoint of education. Each clinic will present many opportunities for teaching if closely analyzed. The resultant value so far as the student is concerned is almost immeasurable and they will be better nurses!

Why I Choose Nursing

PAULINE CAPELLE

In common with others, I want to enjoy the abundant life. To me that means economic and social security with opportunity for growth. Is nursing the answer? Does it meet these needs? Let us analyze nursing in relation to these criteria and try to find out.

At present we have not yet achieved complete economic security, but we have made strides in that direction. Many hospitals and the majority of public health agencies have pension plans; and provision has been made for participation in health insurance projects which provide hospital and medical services in case of illness. Unquestionably salaries are still inadequate. However, since the principle of the certified bargaining committee has been accepted by the Canadian Nurses' Association, and its use is in the process of being implemented by the provincial associations, we may look for more favorable progress in that direction, provided, of course, that every nurse gives support to her association. Individually we must accept the fact that these are confused and critical times and that we

can solve our common problems only by united thought, planning, and action.

Social security is the next topic for investigation and it is a tremendous one. However, for our purpose let us consider it (1) as the availability of those environmental and cultural factors which enable one to live graciously and (2) an assured place in the esteem and respect of our fellow human beings. Certainly the environmental and cultural factors in the life of the average nurse leave a lot to be desired. Living in residence has many drawbacks, while the nurse confronted with lack of adequate housing and exorbitant rents faces an even more discouraging situation. With the current acute shortage of nursing personnel, it behooves boards of directors to provide attractive housing at reasonable rents for their nursing staffs. Moreover, in the more remote areas, provision should be made for recreational facilities which will meet physical, mental, and cultural needs (i.e., a good library containing both fiction and non-fiction; a combination radio-phonograph with

well-selected records: provision for participation in various sports). Moreover, hours and working conditions should be such that the nurse, just as any other normal human being, will have the time and inclination to engage in such activities. turmoil of the present day subsides many of these conditions will tend to correct themselves. Nevertheless it is important that we know where undesirable conditions exist so that we may prepare for their amelioration as soon as possible. Here again we should be able to make use of our nursing organization as liaison agent to collaborate with employers of nurses to correct such defects.

As for our status in the community, surely no group is in a more happy position. With the exception of Sairey Gamp and her ilk, we have an ancient and noble lineage of which we can be justly proud. We hold our enviable position in community life because our professional ancestors met the challenge of human need and That challenge is still suffering. with us and we must meet it to justify our existence as a profession. Service is obviously a basic principle of living and it is only when we conform to that principle that we really live. Mrs. F. Heal, a former instructor at the University of British Columbia, expressed the thought aptly in the following words: "We all enjoy bedside nursing because it makes us feel a little bit like God."

Now for the final question: "Is there scope for growth in nursing?" One can truthfully answer that there are greater opportunities today than ever before. New fields are constantly opening up. For example: there is unprecedented expansion in public health; the increased demands for hospital and medical service continue to defy all efforts to meet them; an ever-growing body of medical knowledge requires highly trained nursing personnel; teaching, supervisory, and administrative positions in hospitals and nursing schools are begging for qualified people to take them, and the new World Health

Organization challenges those interested in the international field. If we can't grow under such stimuli the lack lies in ourselves. Our nursing associations through placement service are making a real contribution to professional growth by endeavoring to place the right people in the various positions available. However, they will only achieve their utmost usefulness as they receive the support of every nurse.

Having surveyed the pros and cons of the situation let us now attempt to arrive at some conclusions. While nursing is not a lucrative profession and at present does not provide economic security, steps have been and are being taken to remedy this situation. Moreover, the remedy will come only through concerted action of all nurses working out their own problems through their own organizations. While many factors contributing to gracious living are not available to all nurses, we have an established position in the esteem and goodwill of the public. The unjust and unfair practices which exist in some instances can be remedied by making them known and negotiating with employing agencies for their amelioration. The bargaining agent of choice is, of course, our own nursing organization. Nursing unquestionably provides opportunity for growth.

True enough, "Rosie, the Riveter" or the woman who does housework by the hour may make more money, but money can't buy happiness; it has to be earned and nursing provides a unique opportunity to earn it. Nursing enables us to develop those aptitudes and skills whereby we can best serve our fellow-men and in so doing develop that which is best in ourselves. One believes that when first things continue to be first, the factors which are necessary to an abundant life will be won. Thus, I for one, choose to remain in nursing, knowing that as long as we retain our sense of values we will achieve the better conditions for which we are striving and at the same time maintain our

professional integrity.

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Poliomyelitis

MARGARET MCINTOSH

NTERIOR POLIOMYELITIS or, as A it is commonly known, infantile paralysis, is an acute systemic, infectious disease which may occur sporadically or in epidemic form. It is characterized by involvement of the central nervous system. Though the greater attention which has been focused on it for the past few decades gives the impression that it is a new disease, cases of sudden paralysis have been recorded in the literature since ancient times. In 1890, a Swedish physician launched the modern study by his observations of the various forms occurring during an epidemic. Its communicability was described by Wickman in 1906.

EPIDEMIOLOGY

Poliomyelitis is one of the most baffling of the communicable diseases. The mass of data assembled by the eminent scientists, who have been conducting research into the cause, seems to indicate that the disease is due to the action of a specific filterable virus. There appear to be several strains. Though apparently fairly resistant to chemicals, the virus is destroyed by heat.

Infection occurs almost universally though cases are more frequent in the cooler part of the temperate zones, with the highest incidence in late summer and early autumn. Children are considered to be more susceptible than adults, males being attacked more frequently than females usually in the ratio of three to two. No race

appears to be immune though the incidence is sharply lower among

Negroes.

A characteristic of poliomyelitis is that the severe epidemics appear to occur in waves or cycles of from twelve to fifteen years. This fact has been noted in Montreal with peak epidemics occurring in 1916, 1931, and 1946. There is no scientific evidence that the termination of an epidemic bears any relation to a sudden change in the weather such as a heavy frost.

It has been stated that, in an epidemic, cases occurred with greatest frequency in the age group under ten. Figures assembled following the outbreak in Montreal last year showed that this was substantially our ex-

perience:

1-4 years...... 29.4% 5-9 years...... 31.8%

61.20%

An annual incidence of 10 cases per 100,000 population is considered ordinary. In general, one attack confers life-long immunity though a few authentic cases of a second attack have been reported.

TRANSMISSION

Poliomyelitis is spread largely by respiratory contact with an infected person. The virus probably enters the body by way of the nose or mouth. The possibility of transmission indirectly through water, milk or by insects, chiefly flies, cannot be com-

pletely disregarded though reliable evidence of spread by these means is

lacking.

However, even in large families where there are countless opportunities for close contact and thus direct transmission, usually only one child will suffer from an attack. This suggests the probability of subclinical attacks so moderate that they do not present any of the customary symptoms but which are capable of stimulating the body to develop an immunity.

SYMPTOMOLOGY

With a variable incubation period considered to be from seven to fourteen days, the onset is marked commonly by a low grade fever which may be accompanied by headache, nausea and vomiting, coryza, drowsiness alternating with irritability. The principal symptoms observed during the last Montreal epidemic were: high fever, severe headache, nausea and vomiting, stiffness in the neck accompanied by irritability and very often pain and tenderness in the extremities. Gastrointestinal disturbances were found in some cases.

The meningeal irritation leading to a general hypersensitiveness of the skin over the entire body and pain which accompanied movement of affected areas lasted from three or four days up to two weeks. In quite a large number of the cases no paralysis followed. In others, the paralysis remained at a certain stage for several weeks, then appeared to improve. The lessening of the paralysis continued gradually until, in many cases, normal muscle action returned and the case would be discharged. In a relatively small percentage of the cases the paralysis persisted.

Case-Finding

The Montreal City Health Department marshalled its forces quickly to meet the epidemic. Case-finding was carried on in co-operation with:

- 1. The family doctor.
- 2. The visiting nurses in voluntary and official organizations.

3. Clinics for well children as well as the hospital clinics.

4. Hospitals of the city and district.

As a result of correct information concerning the disease being given the public by means of pamphlets, newspapers, and radio, the citizens knew that prompt medical attention was needed on the appearance of the slightest symptom.

Pamphlets were issued by the City Health Department and gave such

information as:

1. Description of the disease.

2. General advice for daily living with special attention to: (a) fresh air; (b) sunlight; (c) sanitation of foods, liquids—water and milk; (d) clothing; (e) household surroundings; (f) gatherings of children in public places and travel.

Instructions on the action to be taken at the appearance of any of the following symptoms: prostration, headache, nausea and

vomiting, diarrhea, etc.

These pamphlets were available on Clinics distributed them and nurses on their visits to homes drew attention to them. Explanations were given when the occasion warranted it. Family doctors were most co-operative in sending suspected, as well as diagnosed cases, to hospital without delay. Parents telephoned health centres and clinics for advice. A nurse from the Health Department was immediately sent to the home to investigate. If there was a possibility of danger, a doctor from the Health Department staff was sent to the home. This case was kept under observation by this doctor until a family physician was called in. When the latter was called, contact was maintained by the Health Department to ensure medical supervision. If poliomyelitis was suspected and the family was unable to afford their physician, the health officer would send the patient to a hospital for definite diagnosis.

Suspected cases were kept under observation for ten days before they were declared free of contagion. The household during this period was under observation until official notice declared the home free of contagion.

CONTROL MEASURES

The direct prevention and control program might be listed under the following main headings:

- 1. The immediate reporting of all confirmed and suspected cases to the City Health Department. This report was followed by control visits made by members of the staff.
- The immediate isolation of the suspected as well as confirmed cases.
- On hospitalization of the patient, the home remained under quarantine for ten days. Persons earning their living were allowed to go out but the remaining members of the family were isolated from the community.
- 4. Food-handlers (individuals in contact with foods while earning their livelihood) were required to remain in quarantine for ten days.
- 5. If another case appeared and was hospitalized, the quarantine was extended ten days from the onset of the latter case. A nurse from the Health Department made visits to the home on the first, fifth, and tenth day to observe the health of the family and to give advice and instructions needed during this period.
- 6. When the patient remained at home a nurse from the City Health Department made a visit immediately on notification of the case by the family physician. On this visit a placard was placed in full view of the public where it remained for twenty-one days. If another case appeared in the family, the quarantine period was extended twenty-one days from the onset of the latter.

All members of the household were required to remain under quarantine unless they resided elsewhere during this period. In the latter case, they were kept under observation for ten days. Children were excluded from school for three weeks after contact with the patient.

All food-handlers were kept under strict quarantine for the twenty-one day period. If these persons changed their place of abode when diagnosis was made, they were required to remain from work for the period of ten days. Permits to return to work were issued by the Health Department.

The isolation of the patient was to be carried on in a clean, bare room screened against insects. Contact with the patient was to be made only by the person caring for him. Proper isolation technique was carried on by this person as well as the doctor and nurse in attendance.

Visits were made by the Health Department nurse at least four times during the quarantine period and more frequently if necessary. On these visits advice and instruction were given and might be listed as:

- 1. The manner and importance of proper isolation technique.
- 2. The concurrent disinfection of all articles in contact with the patient.
- 3. The elimination of all unnecessary dust.
- 4. The pasteurization of milk and the boiling of all drinking water as well as water used in the preparation of foods.
- 5. The proper cleaning of all foods eaten, particularly careful washing of all fruits and vegetables to be eaten raw.

The regular habits of eating, sleeping, and resting were carried on while the patient was in bed. Special attention was given to affected parts by keeping them in their normal position to prevent deformity. The limbs affected were kept at rest. Medication and treatment were given according to the orders of the attending physician.

The placard was removed at the end of the quarantine period and "return to work or school" notices were given by the Health Department nurse. Follow-up visits were made by the nurse after the quarantine period to give advice on general care. Instructions were given on such points as:

points as.

1. To carry out orders given by the physician.

- To guard against fatigue of the affected parts as well as the whole body.
- 3. For normal, healthy living, adequate diet, sunshine, fresh air, sleep and rest.
- 4. To encourage the patient to attend clinics promptly on appointed dates.

Future plans were also made for education, and vocational guidance in cases of severe deformities.

In order to aid and support the work of the department, at the suggestion of Dr. Groulx, director of the

Department of Health, an advisory committee was set up to discuss ways and means that might be taken in the control of the disease. Points taken into consideration by the committee were:

- 1. Investigation into the number of known case as well as the rate of daily increase.
- Investigation as to the possible sources of the disease and action for prevention and control of these sources.
- 3. The availability of hospital and trained personnel.
- 4. The need of equipment with which to carry on treatment of the patients. Endorsing the aid of such organizations as the Infantile Paralysis Fund, Red Cross, and other voluntary organizations.
- 5. Education of the medical group by way of lectures.

In the schools the teachers were informed of the seriousness of poliomyelitis. The need for strict observation of the slightest deviation from normal behavior was stressed. child not appearing well was sent to the medical office of the school where the nurse took the temperature and the child was sent safely home. home visit was made that day and medical supervision was required by the family physician (or school medical inspector). This child was re-admitted to school only when an official notice declared no contagion present.

The school nurse was required to visit each of her schools daily. In this way children, reported to the principal in her absence, were visited in their homes. All classes were visited by the nurse and instructions were given on the rules of health. The need for sleep, rest, and the combatting

of fatigue in play were stressed. The thorough cleansing of vegetables and fruits was explained and the general advice given publicly was again repeated in a more simple form.

Deserving praise should be given to the hospitals, especially Ste. Justine, Alexandra, Pasteur, and Children's Memorial, for their untiring efforts in this work. Nurses of the Health Department staff, as well as voluntary health agencies who were loaned to the hospitals, should be included in the above commendation. Individual help from all walks of life, including societies such as the Red Cross, etc., was sincerely appreciated. Supplies, such as woollen and flannel blankets, were donated by the public for use in hot packs. Reading material, toys for children were also received. Money for the carrying on of treatment for the underprivileged was raised by private agencies. Iron lungs were donated by companies through the generosity of employers and employees.

The co-operation of anxious parents, in reporting the slightest symptom of a patient, showed their desire to protect others as well as their own. The shining example given by this, a cosmopolitan city of a million and a quarter population, is one that will always remain with the residents of Montreal and the people of our country.

The author wishes to express her appreciation for advice and aid given to her by Dr. Laporte, Director of Child Hygiene, Montreal City Health Department; Dr. Gervais, Director of Contagious Diseases Division, Montreal City Health Department; and Miss M. Ritchie, Supervisor of Nurses, English Section, Montreal City Health Department.

Blood Test Survey

In line with a resolution passed recently at a venereal disease panel discussion, the National Social Hygiene Committee of the Health League of Canada has decided to conduct a survey of all Canadian hospitals to find out to what routine blood tests for the

diagnosis of syphilis are performed on all admissions.

Also, a sample survey will be made in industry to ascertain to what extent preemployment physical and clinical examinations, including blood tests, are provided.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Transfers, Discharges, and Methods of Resigning

SISTER MARY BEATRICE, C.S.M.

THERE IT WAS on the superintendent's desk—another resignation! But so much better than most of them today!

Dear Miss Stuart:

I hereby place my resignation to be effective on July 31, six weeks from this date. When we came on the staff, we agreed to give one month's notice. I thought you would appreciate an extra two weeks' time. I expect to take a position in a hospital in Western Canada, mostly because I wish to see life outside my own province.

Before leaving, I wish to express my appreciation of the many courtesies extended to me by yourself and your staff. It has been suggested that nurses leaving the staff offer constructive criticism which might be of benefit to our successors. My opinion is that most graduate nurses prefer weekly rotation of "hours-of-work" rather than monthly rotation. Afternoon and night work would then be more favorably looked upon.

I wish to say, also, that a newly-graduated nurse, such as I was, can learn a great deal in this hospital. I am grateful to the heads of departments, supervisors, and others from whom I acquired much in the last two years.

(Signed) Teresa Boyce

Miss Boyce's resignation showed fine consideration of the employer's point of view. Are there situations in which a longer notice of resignation might be expected? Miss Stuart has another resignation from a head nurse in the pediatric ward. This head nurse had had her plans made some months before. In view of the fact that the hospital had given her a leave of absence to take a postgraduate course in pediatrics, and also because there were no other nurses available who had such a course, it would seem that this head nurse should, if possible, give three months' notice of resignation. During this time, another nurse might be at least partially prepared to fill the vacancy.

But what of the nurse who gives the superintendent one week in which to find a nurse interested in the vacant position—and who in turn must give notice before she is available? It is doubtful if there is real necessity for any of these short notices so prevalent today. The superintendent of the second hospital to which the nurse is going knows that the superintendent of the first hospital must receive fair notice of resignation.

The "unkindest cut of all" comes during vacation time! Suppose that the superintendent arranges—with the utmost difficulty these days—to give each graduate nurse a month's vacation. Towards the end of July she receives word that a nurse who is at the end of her vacation, and whose name was posted to relieve for vacations during August and September, is not returning, or will return to give one week's notice of resignation. Can

OCTOBER, 1947 783

you imagine the superintendent's plight? There are right and wrong

methods of resigning!

The Golden Rule would seem to be applicable to methods of resigning. But is the employee in this case capable of appreciating the difficulties of the employer? For example, a group of nurses decide to go east. Another group from the same staff decide to go south—at the same time. If notice is short in these cases, the hospital management will not be able to absorb the shock of disruption without some effect on the service to patients. This should be obvious to the nurses. But it may be difficult for them to understand that it is easier to replace a small number at short notice than a large number.

Can the word "resignation" be applied to the following case? Two nurses apply for positions in a hospital at a great distance. By correspondence, the applicants are accepted for a certain date and agree to report for duty. The hospital ceases its search for nurses for these two positions. When the nurses arrive, they are unfavorably impressed with the city—and possibly with the hospital. The first day consists of orientation. In the evening the nurses get together and decide that tomorrow they will tell the superintendent they are moving on to another city where they know they can obtain work. In vain the superintendent explains that she has no one to replace them. They know the other positions are open. They feel that officially a notice of resignation should not be demanded because they are not long enough on duty to be considered part of the staff. Certainly a notice of resignation is required, but education on this point is apparently necessary for our nurses. The case mentioned is not imaginary -the writer knows of several.

Perhaps our younger or less experienced nurses have not had explanations as to the train of troubles which may follow an inadequate notice of resignation. We should like to appeal to all instructors and directors for their help on this problem. However, even in this day there are

many wonderful nurses who are not only considerate but generous in the matter of vacations and resignations. These lend glory to the profession. An example comes to mind of a nurse who gave notice of resignation, saying, ".... but I shall stay until most of the vacations are over." Her name is held in benediction! We would recommend tangible proof of appreciation.

DISCHARGES

In these days of better personnel policies and long-view personnel management, we like to think that all discharges are in the best interests of the person discharged, as well as the institution concerned. Probably no discharge occurs today which is not evidently a necessity. If the cause is inefficiency, which could be corrected, the nurse has the situation placed before her and is asked to improve, before steps are taken for her discharge. Failing to improve she is given one month's notice. The same procedure is taken for less grave moral offences. When the offence is more serious, a different procedure is usually followed. When definite proofs of a serious offence are available—or when it has been made public and is a direct violation of a known ruling the hospital management usually decides to discharge the guilty party and to do it immediately. However, certain steps are taken. The nurse is told of the offence and its evidence: and is given an opportunity to state her side of the case. Failing to improve her position, she is usually paid in advance in lieu of notice for the same amount of time as would have been asked of her in notice of resignation.

Unless narcotics are involved, most superintendents are willing to help the discharged person obtain another hospital position as a "second chance" or rehabilitation. In the case of narcotics, work other than nursing may be better for a time. A busy superintendent of a large hospital should have a personnel director who would advise and help in such cases.

If the time should come again when

the supply and demand of nurses are more nearly equal than they are to-day, the question of discharges would loom larger on our horizon. Finer shades of efficiency would be watched for. Then, too, greater care would have to be taken to avoid superficial judgment of efficiency. Favoritism and aversions would have to be discounted. The nurse should always be given a chance to meet the standards required. She would have the right to demand the same amount of time of notice as is demanded of her in resigning.

TRANSFERS

Transfers do occur in hospitals, but it appears as if they were kept at a minimum on the nursing staff. In other fields, such as the non-professional help in hospitals, effective programs have been carried out with (a) transfers of promotion, (b) transfers of demotion, (c) remedial or salvage transfers. (This latter is sometimes initiated because of difficult personalities, and sometimes helps to eliminate the too difficult.)

Perhaps some samples of conversation over shortage of specially trained personnel may bring out the possi-

bility of transfers:

Characters: Miss Stuart, superintendent Miss Low, director of school of nursing

Miss Stuart: Now that Miss Brown is leaving 3E and there is no other nurse that we know here with a post-graduate course in pediatrics, should we try Miss Green in there?

Miss Low: Miss Green was a good nurse when she had her experience as a student in the children's ward—but I am thinking of the ward teaching in there. I think Miss Black would be less timid. She could be trained to teach. Must we lose Miss Brown? Would an increase in salary keep her? Her postgraduate course puts her salary in a higher bracket.

Miss Stuart: Her salary is higher. A further increase would not hold her. Was she helpful in ward teaching?

Miss Low: Here are her weekly reports. Her records of this work were excellent. She was not accurate, however, about students' efficiency reports. According to her reports, her student nurses were almost always one hundred per cent perfect in everything. I did not succeed in teaching her that the purpose of them was the essential development of the student. She thought of them as old-fashioned, tell-tale affairs. I must do better with the next nurse in there.

Miss Stuart: Did you try teaching these head nurses in a group, during the ward teaching program last year, or was it all individual teaching?

Miss Low: Both. The individual teaching was resorted to when the group teaching was not quite adequate.

' Miss Stuart: Must you do this every time there is a change, for example, in the Central Dressing Room, Nursery, at the clinics and in other departments?

Miss Low: Many of them are teaching — with good results — but have some difficulty about recording it on proper forms. Our difficulty is — too many young, inexperienced assistants.

Miss Stuart: If you can find out where each one is most efficient, and if she likes the work we shall try to hold them. We shall try Miss Black in 3E. There is to be a change also in the Tuberculosis Unit, Miss White is leaving, after five years. How was she at ward teaching?

Miss Low: Very good. However, we are fortunate there. You have another nurse who has had a post-graduate course in tuberculosis, and the same experience, and I think she will be very good in taking an interest in seeing that the students learn all that is to be learned on clinic days.

Miss Stuart: We are fortunate in that this nurse has agreed to transfer to Miss White's place. When you have time, show her your forms and explain them to her. Another problem: For some months we are going to be short a nurse on maternity. Miss Davis does not care to go there because she has not a post-graduate course in obstetrics.

Miss Low: I shall try to make her see that additional experience here is what she needs at the moment — that the supervisors will help her, and that she will be more valuable to any hospital after a few months.

Miss Stuart: We must try to get a more permanent person in the nursery. If possible it should be one with experience or a post-graduate course.

Miss Low: There is one girl on the graduating class who is quite determined to take a

course in pediatrics. She might be interested in 3E and the Well-Baby and Immunization Clinic. Perhaps it is a long way to look ahead, but there are also some going to take advanced work in obstetrics — one of these might be interested in our nursery. Last, but not least, unless we can find an additional instructor with qualifications we must improvise by taking some new graduate nurse to help.

Miss Stuart: If you fail to get a qualified person, how could you use a new graduate nurse to be most helpful?

Miss Low: At supervised study periods — a little help with ward teaching, or with school office work — or she might release one of us at times for these jobs. The best person would be Miss Day. She does good typing, and knows a few phases of the work.

Miss Stuart: I think it is a little too late

to look for her, except in a temporary capacity. She is promised to the Central Surgical Dressing Room. Perhaps her ability could be used there in close direction and supervision of the students. You agree that much teaching is needed there?

Miss Low: (regretfully) Yes. I hope we can find someone with some preparation for our position. Probably the best way to meet these difficulties in future would be to try preparing people for certain jobs.

Miss Stuart: Yes. In general, there are disadvantages as well as advantages in transfers. A considerable amount of planning and adjustment is necessary. The person responsible for personnel direction must consider the advantage or otherwise to the nurse being transferred — also the supervisor whom she is leaving, as well as the supervisor to whom she is going.

In Memoriam

Martha Jane (Marriott) Clapp, a native of Hamilton, Ont., and a graduate of the Marine Hospital, St. Catharines, died on July 17, 1947. After graduation, Mrs. Clapp lived for a number of years in Buffalo.

Mary M. (Ray) Francis died in Winnipeg on July 21, 1947. Born near London, Ont., Miss Francis came to Winnipeg fifty years ago, graduating from the Winnipeg General Hospital in 1901. She had been a private nurse until her retirement ten years ago.

Mrs. Lucy D. Morgan died in Toronto on July 11, 1947. A native of Michigan, Mrs. Morgan graduated from Misericordia Hospital, Green Bay, Mich., coming to Toronto in 1912. She joined the St. Elizabeth Visiting Nurses' Association completing thirty years' service four years ago when she retired.

Laura A. Schwalm, a native of Hawksville, Ont., died on July 4, 1947, in Winnipeg. A graduate of the Winnipeg General Hospital, Miss Schwalm practised private duty for six years, later joining the Regina General Hospital staff. In 1918 she became a child welfare nurse with the Bureau of Child Hygiene, City Health Department, completing twenty-nine years' service with the department at the time of her death.

Jessie Penelope (Bonnor) Taylor died at Belleville, Ont., on June 17, 1947. A native of Sintaluta, Sask., coming to Carnduff in 1914, Mrs. Taylor received her B.A. from the University of Saskatchewan. Teaching school prior to entering the Winnipeg General Hospital, she graduated in 1938 with two scholarships. After attending McGill University she joined the teaching staff of her home school. Enlisting with the R.C.A.M.C., Mrs. Taylor went overseas with No. 20 Canadian General Hospital being awarded the Oak Leaf for distinguished service.

Alice Williams, a graduate of Women's Hospital, San Francisco, died on April 18, 1947, at Victoria, B.C. Miss Williams served during World War I with the C.A.M.C. in England and France. On her return to Victoria she did private duty and also served on the Nurses' Registry.

Preview

Many of us have seen the current film "I Know Where I'm Going." Do we have much idea of the directions in which nursing is heading? Eleanor MacIntosh of Toronto has prepared a thoughtful analysis of "Trends in Nursing Education" which points up many of the current developments.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Etude sur la Réhabilitation des Anciens Tuberculeux

LAURENTINE GERMAIN

Nous terminons par le travail que présente Mlle L. Germain, infirmière hygiéniste de la Metropolitan Life Insurance Co., une série d'articles sur la tuberculose. Nous avons voulu attirer l'attention de nos lecteurs sur la grande campagne anti-tuberculeuse, que poursuit actuellement le gouvernement de la province et aussi afin de voir ce que nous, infirmières, pouvons faire de constructif pour seconder ces efforts.

Maladie sociale, la tuberculose exige donc un effort de la société entière; la tâche paraît immense et elle l'est. Elle ne sera accomplie que si tout le monde — médecins, malades, familles, industriels, pouvoirs publics, éducateurs, etc.— s'unissent contre elle dans un effort concerté de compréhension, d'instruction, et de collaboration pour la réhabilitation des ex-tuberculeux.

Après les débuts difficiles du sanatorium, des perspectives d'incertitude et d'anxiété, moments où l'on croyait à tout jamais trancher les liens qui rattachaient au passé heureux, viennent les classements, présages de la guérison complète. On permet un travail léger, puis vient la première

paye, quelle émotion!

Une école de réadaptation fut fondée il y a quelques années à Saranac Lake: le "Study and Craft Guild" s'en occupe. On offre au patient l'avantage de s'instruire, de développer ses facultés, puis la direction de l'école s'entend avec le médecin traitant. S'il accorde à son malade la permission de suivre les cours, on soumet ce dernier à un test d'orientation professionnel.

L'ecole "Study and Craft Guild" relève du département d'instruction publique des Etats-Unis. Les cours

coûtent de 50 c. à \$5.00 par mois. On les donne gratuitement à ceux qui sont incapables d'en défrayer le coût.

L'école de réadaption forme à tous les arts et métiers. On y donne aussi des cours de clinique ambulante antituberculeuse, les cours théoriques durant six semaines et sont suivis de six autres semaines d'entraînement pratique dans une roulotte. On vise donc à choisir des techniciens parmi les anciens tuberculeux qui montrent des dispositions pour ce travail. Les hommes et les femmes suivent ces cours.

En 1941, l'école eut à faire face à certaines difficultés financières. La cantatrice, Grace Moore, de regrettée mémoire, dont le mari souffrait de tuberculose, donna un concert pour aider l'école qui, de ce fait, prit l'essor.

Ecoutons M. Benton Helligar, du service de réadaptation du Sanatorium Queen Alexandra, dans l'ébauche de son programme. M. Helligar insiste sur le fait que la réadaptation débute en réalité dès le jour où le malade est hospitalisé. A son avis, dans tous sanatoria un membre du personnel autre qu'un médecin devrait être chargé de cet important aspect du traitement. Dans certaines institutions américaines, cette tâche est

OCTOBER, 1947

remplie par une personne s'occupant d'oeuvres sociales, tandis qu'à d'autres endroits il existe un comité dont les membres visitent les tuberculeux. Le comité se compose de convalescents qui, sous la direction du médecin, vont causer avec les nouveaux malades pour leur expliquer certain points de la routine sanatoriale.

L'une des diverses fonctions du préposé à la réadaptation est de s'occuper des problèmes du malade, afin de le soulager autant que possible des soucis qui peuvent nuire à sa guérison. Plus tard, lorsque le tuberculeux prend du mieux, surgit pour lui la question de savoir employer son temps. C'est alors qu'il a besoin des services d'un guide ou d'un spécialiste en thérapeutique professionnelle. Les programmes radiophoniques sanatoriaux, captés au moyen d'accoustiques, de même que les bibliothèques, peuvent être utiles à ce stade. Enfin, il faut un spécialiste de l'orientation professionnelle pour conseiller les malades dans le choix d'une occupation à sa sortie du sanatorium.

La réhabilitation ne va pas sans éducation; une des premières tâches qui incombent est de règlementer le surmenage scolaire, professionnel et moral, en même temps le sport que l'on pratique souvent d'une façon

trop déréglée.

Pour aider les ex-T.B. divers mouvements se forment. Le Sanatorium de Sherbrooke offre son petit hebdomadaire "Espoir," celui du Lac Edouard, "Etoile du San," Montréal a sa "Croix de Lorraine," association qui aide à trouver, d'après la capacité physique et intellectuelle, un travail assez bien rémunéré à tous les extuberculeux qui se présentent.

Son président, M. Euclide Simard, forme de beaux projets pour l'année à venir: Fonder un refuge pour ceux qui n'ont aucune famille. L'Honorable Henri Groulx projette la formation d'un comité de patrons d'honneur calqué sur le club St. Laurent Kiwanis; M. Monast, président de la Ligue Anti-Tuberculeuse, suggère d'inviter un conférencier, ancien tuberculeux.

Si les projets actuels se réalisent,

la province de Québec disposera d'environ 1,200 lits de plus pour la tuberculose. L'Honorable A. Paquette a dressé les grandes lignes de quelquesuns des projets envisagés dans les cadres du programme de \$10,000,000; entre autres choses, le gouvernement se propose de reconstruire l'Institut Bruchési de Montréal; ce qui donnerait environ 500 lits de plus. plus on est à aménager deux nouveaux sanatoria à Gaspé et Dorchester et une aile à celui de Trois-Rivières; ce qui met à la disposition des tuberculeux plus de 400 lits. est clair que la plus grande partie de ces millions ira à la construction d'hôpitaux et de sanatoria afin de doter la province de Québec et principalement Montréal du nombre de lits suffisants pour répondre aux besoins. La situation est des plus intolérable. Les tuberculeux qui attendent leur tour pour entrer à l'hôpital en sont rendus à patienter en moyenne 52 jours.

On fait, avec raison, de la publicité à outrance sur ce fait que la tuberculose, prise à point et convenablement traitée, est facile à guérir. En conséquence le dépistage des tuberculeux a été fortement poussé. Mais c'est là qu'apparait tout le tragique de la situation. On imagine facilement l'angoisse du tuberculeux qui se sait malade, parce qu'on le lui a dit, qui sait en plus que ses chances de guérison diminuent en proportion du retard qu'il apporte à se soigner, et qui se voit condamné à attendre jour après jour, semaine après semaine, et mois après mois, une place à l'hôpital. Se soigner chez lui, dans la majorité des cas, est pratiquement une impossibilité dans les conditions actuelles

du logement.

Si l'on regarde en arrière, on a raison d'être satisfait des progrès réalisés; il ne faut pas en rester là toutefois; la lutte continue avec un seul objectif—la victoire complète. Nos problèmes sociaux sont nombreux et urgents. Aurons-nous toujours des hommes (ou des femmes) d'énergie et de décision qui sauront prendre les mesures radicales et immédiates pour les solutionner.

Do You Want to Win Some Money?

YAN YOU PAINT? Can you draw? If so, will you pit your skill against your colleagues in the brand new Canadian Nurse poster competition?

Every two years the Canadian Nurses' Association has its convention. At that time, along with many commercial exhibitors, The Canadian Nurse has a booth which is visited by the majority of the nurses attending the convention. In order to attract as much interest as possible, good posters are very essential. It is in the hope of building up a useful collection of posters which can be adapted to The Canadian Nurse booth at provincial conventions as well as at the biennal that the Journal is sponsoring this poster contest. It is open to all nurses, both students and graduates. The competition starts now and closes March 31, 1948. Nine prizes of \$15 each will be awarded for

the best entry from each province. The best of the nine prize-winning posters will receive an additional prize of \$15. All posters submitted become the property of The Canadian Nurse.

A committee of judges in Montreal will make the selection for each province. To simplify storage no posters should be larger than 24 x 36 inches. The posters will be judged on the basis of their artistry, their sales value, and their suitability for Canadian Nurse publicity work.

One suggestion which has already been received in this regard is that each hospital school of nursing should stage inter-class competitions with the best posters from this source being submitted for the provincial prize.

Think about it! Talk about it! Get busy! Let us make this poster competition an outstanding success. Some people are going to win this \$150. Who will they be?

Well Done, Manitobal

When the War Memorial Committee of the Canadian Nurses' Association first outlined the amounts required from each province to permit the full materialization of the Memorial plans to help rebuild the nursing libraries in the war-torn countries, the provincial representatives at the Executive Committee meeting gasped slightly, then passed the figures. The provincial nurses' associations swung into action and collections began. It was optimistically hoped that the sum of \$32,000 could be collected by May 1, 1947. In April, the closing date was extended until December 31, 1947. If absolutely necessary, it can be further extended.

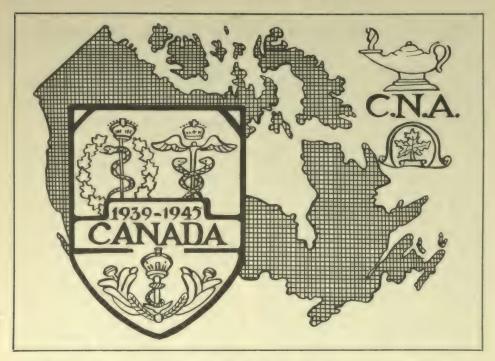
WHAT HAS BEEN THE RESPONSE?

Manitoba donations have climbed faster and proportionately higher than any of the other provinces. At September 1, 1947, the provinces, arranged in the order of the percentage of the original objective, had collected as follows:

100101 000 1011011		
Province	Amt. Coll.	of Objective
Manitoba	\$1,965.40	98.3
New Brunswick	679.35	75.5
Alberta	1,334.30	66.7
Saskatchewan	743.54	46.5
Ontario	4,103.00	41.0
Prince Edward		
Island	80.00	40.0
Nova Scotia	601.00	37.6
British Colum-		
bia	706.00	19.1
Quebec	480.50	4.8
Other gifts	16.00	
Total .	\$10,709.09	33.5

WHAT HAS BEEN ACCOMPLISHED? On direction from the C.N.A. Executive Committee, the War Memorial Committee

749



In Tribute to

All Aurses Who Served in World War 11, 1939 - 1945
from the Aurses of Canada.

has ordered over a thousand medical and nursing texts which will be sent as the first instalment of the libraries to the twenty-two countries which felt the impact of war most grievously. This purchase will use up most of the moneys which had been received up to July 1, 1947. A lot of books, you may say! Yet that purchase represents only fifty books to a country.

The accompanying illustration shows the book-plate which was designed for us by Miss Joyce Rea, R.N., of Vancouver. Embodying the insignia worn by the nursing sisters in the three services within the shield, the background of Canada represents the nurses in all parts of our land who have made this memorial possible by their donations. The book-plate will be affixed to the cover of each book before it is sent overseas.

The members of the War Memorial Committee were very gratified to learn that the fifty-two complimentary subscriptions to The Canadian Nurse, which had been donated for one year at the time of the biennial convention in 1946, have brought such eloquent responses. The committee extended each of these subscriptions for a period of three years.

WHAT NEXT?

If you have already made your contribution to your provincial total, unite with your local committee in interesting others in subscribing. One dollar from every nurse in Canada would give the committee a wonderful sum to devote to this worthy purpose. So far, there are thousands of nurses who have made no donation. Help to interest each one of them. Nor does the giving need to be limited to nurses. Remember, donations may be deducted from Income Tax. Let us reach and pass our objective of \$32,000 before the end of this year.

Notes from National Office

A New Adventure in Program Planning for the Biennial Meeting 1948

L AST WINTER National Office secre-taries prepared a questionnaire designed to determine the interests of the members of the Canadian Nurses' The response to this Association. request was most gratifying. Nurses throughout Canada expressed their desire to participate in refresher courses of various types. "Let's have some workshops on nursing interests at our next biennial meeting," was the request of many nurses. These suggestions were conveyed to the program committee for the 1948 biennial meeting, which is to be held at Mount Allison University, Sackville, New Brunswick, on June 28-July 1, 1948.

Under the convenership of Miss Rae Chittick, president of the Canadian Nurses' Association, the program committee unanimously approved the acceptance of the suggestions submitted by the members of the Canadian Nurses' Association, and plans are now underway for nine workshops to be held for three mornings from 9 a.m. till 12 noon, beginning Tuesday, June 29, through Thursday, July 1. The subjects for discussion will include:

1. Counselling and Guidance

- 2. Labor Relations and Personnel Administration
- 3. Public Relations
- 4. The Adventures of Bedside Nursing
- 5. Newer Methods of Teaching
- 6. Tests and Measurements
- 7. Staff Education
- 8. School of Nursing of the Future
- 9. Job in Training Program

Experts who will also act in a consultant capacity are being invited to direct the workshops, assisted by two or three nursing leaders. Announcements concerning the personnel will be given in a later issue. Outlines to be used as guides for each workshop are now in the process of preparation and will be published in due course. For the reader's convenience we have prepared the following summary from available articles dealing with workshops:

Since workshops for teachers were started in 1936, the term "workshop" has become so popular that it is applied to everything from a summer session of full-time graduate work to a one-or-two-hour discussion meeting

for Sunday School teachers.

Workshops have generally accepted the following characteristics. Many of the features are neither new nor unique but in a workshop they receive special emphasis:

- Each participant has a special interest or a definite problem resulting from his own experience, on which all of his activities are focused. This approach is an adaptation of the case study and problem-solving methods with which nurses are familiar.
- Participants share in the planning of individual and group activities which will contribute to the solution of their problems.
- Resource persons and materials from various fields are readily available to all participants.
- 4. Emphasis is placed on an informal democratic relationship between participants and resource persons or consultants rather than the traditional teacher-student or supervisor-staff relationship.
- 5. It is recognized that each individual has a contribution to make and the experience and special knowledge and skill of group members are utilized. Informal discussions, exchange and pooling of experiences, and cooperative activities are encouraged.

791

6. Through work on a particular problem an effort is made to help the participant gain a broader perspective and better understanding of the basic principles involved.

7. The participant's experience in defining and analyzing one problem teaches him to recognize his real problems and attack them more effectively. Emphasis is placed on applying rather than on acquiring knowledge.

8. Participants learn to evaluate their own

progress.

- Emphasis is placed on socializing experiences which reduce tension and result in a balanced program in spite of intense and concentrated work.
- 10. Flexibility is necessary to provide for individual needs.

In order to obtain satisfactory results from a one-week period, more than the usual amount of advanced preparation must be made, including a tentative daily schedule, assignment of participants to groups on the basis of their expressed interests, and selection of a chairman and secretary for each group. Before completing plans the committee must determine the purposes to be achieved. major purpose should be to provide an opportunity for those participating in the workshop to have experiences which would help them do better the work in which they were engaged and to demonstrate, through the workshop itself, the principles of supervision in action. Other objectives are to help the workshop members to: (1) increase their ability to recognize, think through, and work toward a solution of problems; (2) increase their ability to work co-operatively and productively in groups; (3) learn more about educational experiences and the best sources of information available to them in their particular capacities, and also to develop some ability in their effective use; and (4) to gain perspective of their roles in the total program of nursing.

For a workshop, staff members need broad knowledge and experience in their field and close enough contact with actual problems to be practical and realistic. They should be skilled in group leadership and in defining and analyzing problems, without dominating. They need enthusiasm, an experimental attitude, and a liking

for people.

In considering the strengths of the workshop as an educational method, one must know the objectives of the particular group. The following strengths have been apparent in reports from various workshops:

- 1. Participants are motivated by an immediate problem which they recognize.
- Sources of help are readily available and participants become acquainted with new resources.
- 3. Participants actually experience democratic leadership.
- 4. Participants gain experience in working co-operatively.
- Participants plan their own activities and are not hampered by the requirements or limitations of specific courses or programs.
- 6. Participants learn a method of working toward the solution of problems.
- 7. Participants have time to concentrate and do intensive work on a specific problem.
- 8. Knowledge acquired is applied to a practical situation and material of actual value is produced.
- Participants learn to evaluate their own progress.
- 10. Provision is made for social as well as educational experiences.

Registration: In order that discussion may have free play it is necessary to limit the number of participants in each workshop to a maximum of fifty nurses. It will, therefore, be necessary for the members to select the workshop in which they wish to participate at an early date and to notify National Office accordingly.

The registration fee for the 1948 general meeting will be **Five Dollars**. This will include mimeographed outlines for the workshops and the Canadian Nurses' Association folio of

reports.

Local nurses who may wish to attend individual sessions may do so upon payment of a fee of fifty cents for each session attended.

For the purpose of arranging details concerning the biennial meeting, National Office secretaries motored to Sackville, New Brunswick, to visit Mount Allison University early in

July.

Our visit to Mount Allison University, where we met and conferred with Mr. N. A. Hesler, president of the Board of Governors, Dr. Ross Flemington, the president of the university, and Mr. J. A. Wheeler, secretary-treasurer, proved enjoyable and beneficial. Mount Allison is one of Canada's small but leading universities and has played a role in education out of all proportion to its size. All of those who busied themselves with its founding, and many of those who helped build and maintain its traditions, have long been silent. Great teachers have come and gone, yet their work goes on, for many hundreds of graduates have made noteworthy contributions to the life of Canada: some as college presidents, superintendents of education, judges of the Supreme court, Lieutenant Governors, members of provincial and Dominion Parliament, leaders church and state, in scientific research and in the commercial and business life of the country.

Mount Allison campus is situated on a hilltop in the centre of the town of Sackville, New Brunswick, on the historic isthmus of Chignecto, the geographical centre of the three maritime provinces, and an area as rich in history as many of similar size in all North America. From its vantage point. Mount Allison overlooks the fertile marshes of the Tantramar, so beautifully depicted in the poems of Sir Charles G. D. Roberts, a native son on whom the honorary degree of Doctor of Literature was conferred by Mount Allison University in 1942. Nearby is old Fort Beausejour and the Fort Beauseiour National Park and

Museum.

The trim lawns and stately trees of the college campus, the university park with its lily pond and playing fountain, the ivy-covered college buildings of red sandstone, lend an air of gracious dignity to Mount Allison.

Residence accommodation is adequately provided in Hart Hall and Trueman House. The latter is the

new men's residence and will serve as convention headquarters and will also accommodate the officers and members of the executive. Mount Allison Academy has been selected as the residence for the members of the nursing sisterhoods. Convention rates quoted at the time of visit to Sackville are as follows:

\$3.50 to \$4.00 per day for room and meals. Single meals vary from 50c

to \$1.00.

The Maritime Provinces present a vacation land without parallel. Plan now to spend your 1948 vacation attending the biennial convention and see for yourself the beauties of this countryside, and enjoy the hospitality of the Maritimes and the Maritimers.

Demonstration School

MRST PUBLICLY announced in Jan-Puary, 1947, the plans for the independent school of nursing, sponsored by the Canadian Nurses' Association and financed by the Canadian Red Cross Society, are maturing rapidly. The director of this school, Miss Nettie D. Fidler, has spent a considerable amount of time surveying suggested centres. It was agreed that a hospital of between one and two hundred beds would be the most satisfactory from the point of view of size. Few hospitals of that capacity could be found which did not already have a school of nursing established.

The Metropolitan Hospital, Windsor, which has been selected as the clinical centre, is a fine, modern hospital of 125 beds. In addition to the services which are available there, the school will be able to utilize the facilities of the Essex County Tuberculosis Sanatorium in Windsor and affiliation will also be provided in psychiatric nursing at the Ontario

Hospital.

Under the tentative proposed curriculum, the students will be fully grounded in both theory and practice. Adequate opportunity will be provided for them to acquire all of the necessary nursing skills. The course which is being planned provides for a

three months' probationary period; four months in medical services, including diet kitchen; four months in surgery, including operating-room experience; three months in psychiatric nursing; four months in obstetrics and pediatrics; four months in services connected with communicable diseases, tuberculosis, and public health nursing; to complete the training a period of experience as seniors in ward administration will be provided. A vacation will be planned for all students each year.

The first class will enter the school early in the new year. It had been hoped to have each class start in September. Since negotiations were only completed in August, it was impossible to have the first class com-

mence until January. However, it is planned to admit the second class in September, 1948. Application may be made now for either of these classes to Miss Nettie D. Fidler, Canadian Nurses' Association, 1411 Crescent St., Montreal 25.

The Canadian Red Cross Society has pledged financial support for this demonstration school for a period of four years. The Ontario Nurse Registration Branch has given its assurance that the graduates from this shortened course will be granted full registration status. The whole country will watch this demonstration with interest as they scientifically study the proposition of how long it takes to train a nurse under as nearly ideal conditions as can be provided.

Notes du Secrétariat de l'A.I.C.

Une Initiative dans la Préparation du Programme du Congrès Biennal

Au cours de l'hiver dernier, le secrétariat national préparait un questionnaire afin de savoir ce qui intéressait les membres de d'Association des Infirmières du Canada.

Les réponses reçues furent très satisfaisantes. Les infirmières à travers tout le Canada exprimèrent le désir de suivre des cours postscolaires (refresher courses) variés. "A notre prochain congrès biennal ayons des cercles d'études sur des questions intéressant les infirmières" telle fut la demande de plusieurs.

Ces suggestions furent envoyées au comité du programme du congrès biennal de 1948, qui sera tenu à l'Université de Mount Allison, Sackville, Nouveau-Brunswick, du 28 juin au 1er juillet.

Le comité du programme, dont la convocatrice est la présidente de l'A.I.C., a accepté les suggestions soumises par les membres de l'association et l'on est à préparer neuf cercles d'études. Durant trois matinées de 9 à 12 heures du mardi, 29 juin au jeudi, 1er juillet, ces cercles étudieront les questions qui leur auront été soumises tel que: (1) Orientation et direction; (2) relation du travail et administration du personnel; (3) relations extérieures; (4) expériences en service privé; (5) nouvelles méthodes d'enseignement; (6) épreuves et mensurations psychiques; (7) enseignement du personnel; (8) l'école d'infirmières de l'avenir; (9) expérience spécialisée acquise en occupant certaines positions.

Des spécialistes seront invités, à titre de consultants, à diriger ces cercles d'études; ils seront aidés dans leur travail par deux ou trois infirmières réputées dans la profession. L'on publiera dans un prochain numéro le nom de ces personnes. Des données générales pouvant servir de guide à chaque cercle d'études sont en préparation et seront publiées en temps et lieu.

Pour la satisfaction des lecteurs, nous avons préparé le résumé suivant sur des articles concernant les cercles d'études:

Les institutrices se sont réunies en cercle d'études en 1936 et depuis ce temps le terme cercle d'études (workshop) est devenu si populaire qu'il s'applique aussi bien à un cours d'été donnant droit à un certificat qu'à une discussion de quelques heures.

Les cercles d'études sont souvent caractérisés par les traits suivants. Bien des sujets à l'étude ne sont ni nouveaux, ni uniques, mais une nouvelle importance leur est donnée au cercle:

1. Chaque membre a un intérêt particulier ou un problème bien défini, résultat de son expérience, sur lequel il concentre tous ses efforts. C'est un peu comme une histoire de cas ou la solution d'un problème posé, méthodes d'enseignement familières aux infirmières.

- Chaque membre a son mot à dire dans la préparation du travail du groupe ou dans le travail assigné à chacun d'eux, afin de trouver la solution du problème à l'étude.
- Des hommes de ressources dans tous les domaines peuvent être consultés par les membres et toutes sortes de renseignements sont mis à la disposition de tous.
- 4. Les réunions se font sans aucune formalité entre les membres consultants et experts. Les relations sont démocratiques; il n'y a pas cette attitude traditionnelle de maître et d'élèves.
- Il est reconnu que chaque membre a une contribution personnelle à faire, les connaissances, l'expérience et l'habilité personnelles sont utilisées, le travail en co-opération est encouragé.
- 6. En travaillant à un nouveau problème l'on s'applique à faire voir aux membres un point de vue plus large de la question et à faire mieux comprendre les principes qui s'y rattachent.
- 7. L'expérience que les membres acquièrent en définissant et en analysant un problème leur enseigne à reconnaître leurs propres problèmes et à les résoudre avec efficacité. L'on insiste sur l'application des connaissances plutôt que sur l'acquisition de nouvelles connaissances.
- Les membres apprennent à évaleur leurs progrès personnels.
- 9. L'on insiste sur les expériences communes, ce qui facilite l'exécution d'un programme bien préparé même si il est chargé et si le travail est intense.
- Le programme doit être exécuté avec souplesse afin de répondre aux besoins de chacun.

Pour obtenir des résultats satisfaisants d'une semaine d'étude, il faut que la préparation soit plus élaborée que pour la réunion ordinaire d'un cercle. Cette préparation doit comporter le programme quotidien d'après l'intérêt de chacun, la formation des groupes, le choix d'un président et d'un secrétaire pour chaque groupe. Le but que l'on veut atteindre doit être déterminé avant que le programme soit completé. Le but principal devrait être de fournir à ceux qui prennent part à ces réunions d'étude des expériences qui les aideront à faire mieux leur travail, et de démontrer même lors des cercles d'étude

l'application pratique des principes de surveillance.

Les buts secondaires sont d'aider les membres du cercle d'étude à: (1) Reconnaître avec plus d'habilité leurs problèmes, à les analyser avec plus de soin, et à travailler à leur solution. (2) Les rendre plus aptes à travailler en groupes et à produire en commun. (3) Apprendre à mieux connaître les expériences éducatives et les sources de renseignements pouvant convenir aux membres du cercle et aussi leur apprendre à s'en servir avec succès. (4) Voir, sur son vrai jour, dans l'ensemble des buts à atteindre par la profession, le rôle que chaque infirmière, membre du cercle, a à jouer.

Les membres dirigeants du cercle d'étude doivent avoir une connaissance et une expérience profonde du sujet qu'ils ont à traiter et doivent être suffisamment au courant des problèmes actuels pour pleinement les réaliser et être pratiques dans leurs solutions.

Ils doivent être habiles à conduire un groupe à définir et à analyser un problème et celà sans dominer. Ils ont besoin d'enthousiasme, d'un désir d'expérimenter, et d'amour pour leurs semblables.

Si l'on considère la valeur d'un cercle d'étude comme méthode d'éducation, l'on doit connaître le but que chaque groupe se propose d'atteindre.

Voici quelques traits saillants tirés de différents rapports de cercles d'études:

- 1. Les participants sont stimulés par la présentation d'un problème actuel qu'ils reconnaissent facilement.
- 2. De l'aide est immédiatement mise à la disposition des membres et de nouvelles ressources leur sont indiquées.
- 3. Les membres participant au cercle expérimentent une direction démocratique.
- 4. Les membres acquièrent de l'expérience au point de vue de travail d'équipe.
- Les membres décident d'eux-mêmes de leur travail et ne sont pas genés par les exigences d'un programme ou d'un cours déterminé.
- Les membres apprennent des méthodes de travail les amenant à solutioner leurs problèmes.
- Les membres ont le temps de concentrer leurs efforts et faire un travail intensif sur un problème déterminé.
- 8. Les membres apprennent à évaleur leurs progrès personnels.
- 9. Les consalssances acquises sont appliquées à une situation d'ordre pratique et

des points de vue de valeur sont exprimés.

 Des dispositions sont prises pour assurer aux membres une expérience sociale et éducative.

Enregistrement: Afin que la discussion puisse se faire librement, il est nécessaire de limiter le nombre des membres de chaque cercle d'étude à cinquante infirmières. Il sera donc nécessaire, pour les membres, de choisir prochainement le cercle d'étude auquel elles veulent prendre part et prévenir le secrétariat national.

L'inscription au congrès de 1948 sera de \$5.00; une copie de données générales sur les cercles d'étude et une copie des rapports de l'A.I.C. seront données à chaque infirmière inscrite.

Les infirmières de la ville pourront s'inscrire pour une séance du congrès en payant 50c. pour la séance à laquelle elles assisteront.

Afin de faire les arrangements nécessaires pour l'organisation du congrès biennal, les secrétaires du bureau national se sont rendues à Sackville, N.B. et ont visité l'Université Mount Allison au début de juillet.

Lors de notre visite à cette université nous avons rencontré M.-N. A. Hesler, président du bureau des gouverneurs, le Dr. Ross Flemington, le président de l'Université, et M.-J. A. Wheeler, le secrétaire-trésorier. Cette entrevue a été agréable et utile. L'Université Mount Allison, bien que l'une des plus petites, a joué un rôle important dans l'éducation et son oeuvre ne se mesure pas à sa taille. Tout ceux qui se sont occupés de la fondation de cette université et plusieurs parmi ceux qui ont travaillé à établir et à maintenir ses traditions sont depuis longtemps disparus.

De grands professeurs ont passé par ses murs, néanmoins, leurs oeuvres demeurent et des centaines de leurs élèves ont contribué de façon notoire à enrichir la vie du Canada, quelques-uns comme président de collège, directeur des études, juges de la cours suprême, lieutenants-gouverneurs, membres des parlements provinciaux et fédéral, comme chefs dans le clergé, l'état, les sciences, le commerce, et l'industrie du pays.

Les terrains de l'Université de Mount Allison s'étendent sur une colline au centre de la ville, dans l'isthme historique de Chignecto. Au point de vue géographique Sackville est le centre des trois provinces maritimes, terre riche en souvenirs historiques. Le Mount Allison domine les marais fertiles de Tantramar, si merveilleusement décrits dans les poèmes de Sir Charles G. D. Roberts, un fils du pays, qui s'est vu conféré le titre honorifique de docteur en littérature par l'Université Mount Allison en 1942. Tout près de là, on trouve le vieux Fort Beauséjour, le parc national Beauséjour, et le musé.

Les pelouses bien entretenues, les arbres majestueux, les jardins avec leurs bassins de nénufars, le lierre couvrant les pierres rouges des murs—tout rend à donner un air de gracieuse dignité à Mount Allison.

Le "Hart Hall" et le "Trueman House" seront les logements mis à la disposition des congressistes. Le "Trueman House" est la nouvelle résidence des étudiants. Elle logera les quartiers généraux de l'A.I.C., les officiers et les membres du comité exécutif.

L'académie Mount Allison sera mise à la disposition des religieuses infirmières. Lors de notre visite à Sackville, les prix courants pour chambres et pension étaient de \$3.50 à \$4.00 par jour. Le prix des repas variait de 50 c. à \$1.00.

Les provinces maritimes sont un endroit de choix pour les vacances. Préparez-vous dès maintenant à passer vos vacances en assistant au congrès biennal, admirer à la beauté de ce paysage, et à goûter l'hospitalité du pays et de ses habitants.

Ecole d'Infirmière Indépendante

Pour la première fois en janvier, 1947, le public était informé du projet d'une école d'infirmière indépendante, sous la direction de l'A.I.C., et dont les frais seraient assumés par la Croix-Rouge canadienne, ce projet semble à la veille de se réaliser. La directrice de l'école, Mlle Nettie D. Fidler, a consacré beaucoup de temps à visiter les endroits suggérés. On était d'accord qu'un hôpital d'environ 100 à 200 lits serait le mieux approprié au point de vue nombre de lits. Il était assez difficile de trouver des hôpitaux de cette dimension qui n'avaient déjà une école d'infirmière.

La Metropolitan Hospital à Windsor a été choisi pour l'expérience clinique. C'est un bel hôpital moderne de 125 lits. En plus du champ clinique offert par cet hôpital, l'école pourra utiliser toutes les facilités qu'offrent le sanatorium anti-tuberculeux du comté d'Essex et le hôpitaux mentaux de l'Ontario.

D'après le programme d'étude proposé les élèves recevront une base solide, en théorie et en pratique. Toutes les occasions seront données aux élèves pour apprendre toutes les techniques nécessaires aux soins des malades. Le cours que l'on est à préparer comporte trois mois de cours préliminaire; quatre mois en médecine avec expérience en diététique; quatre mois en chirurgie, avec expérience à la salle d'opération; trois mois en psychiatrie; quatre mois en obstétrique et en pédiatrie; quatre mois en maladies contagieuses, tuberculose, et en hygiène publique. On verra aussi à ce que l'élève, à la fin de son cours, acquiert une expérience en administration. On se propose de donner des vacances aux élèves chaque année.

La première entrée aura lieu au début de l'année 1948. Nous espérions pouvoir faire l'entrée en septembre mais comme toutes les ententes ne furent completées qu'en août il sera donc impossible de recevoir des élèves avant cette date. Les demandes pour suivre ce cours peuvent être faites à Mlle N. D. Fidler.

La Croix-Rouge canadienne s'est engagée à entretenir cette école de démonstration durant quatre ans. L'Association des Infirmières enregistrées de l'Ontario a assuré que les diplômées qui auront suivi ce cours abrégé recevront leur enregistrement au même titre que les autres.

Le public surveillera cette expérience avec intérêt. Elle a pour but d'étudier, d'une manière scientifique, combien de temps il faut pour former une infirmière dans un milieu aussi parfait que possible.

Annual Meeting in Nova Scotia

The thirty-eighth annual meeting of the Registered Nurses' Association of Nova Scotia was held in Halifax, N.S., on June 11-12, 1947, the hosts for the occasion being the Halifax Branch. All branches were represented, there being an attendance of approximately 110. The invocation was delivered by Rev. Mons. Burns, St. Mary's Cathedral, Halifax, His Worship, Mayor J. E. Ahern, addressed the meeting and extended a most cordial welcome on behalf of the city of Halifax to all delegates. The president, Lillian Grady, presided at all meetings and in her opening remarks stressed the present nursing shortage and the steps which are being taken to alleviate this crisis, and called upon all members to recognize the responsibility to set up and maintain standards adequate to meet these needs. Mimeographed folios, containing reports of all branches and special committees, were distributed to all members in attendance. Many favorable comments were received respecting this procedure. Programs were supplied to each member present by courtesy of the Halifax Branch.

A library booth was erected in the assembly room by the Library Committee in which the latest textbooks and other literature dealing with the profession were on display. These books were loaned for the occasion through the courtesy of J. B. Lippincott Company.

The proceedings of the first day were entirely devoted to discussions dealing with the business and financial affairs of the association. A resolution was introduced and

passed which will hereafter fix the membership year and the fiscal year of the association as ending on the thirty-first day of December in each year, beginning with December 31, 1948. A resolution was also introduced and passed giving effect to an amendment to the by-laws by which the Public Health Section, the General Duty Section. and the Hospital and School of Nursing Section will hereafter correspond with committees as set up by the Canadian Nurses' Association. Authority was given to the Legislative Committee to proceed with the drafting of a Nurse Practice Act to include both the professional nurse and the nursing attendant, the final draft of the proposed act to be submitted to all branches for their approval before being presented to the Legislature.

The annual dinner of the association was held at the Nova Scotian Hotel on the evening of June 11, approximately 120 being present.

The proceedings of the final day were taken up with reports of sections, standing and special committees, and the election of officers for the ensuing year.

The president, who was the delegate of the association to the I.C.N. Congress, presented an interesting and informative report of the proceedings of the Congress.

An invitation has been accepted to hold the next annual meeting in Antigonish.

NANCY H. WATSON Registrar, R.N.A.N.S.

Annual Meeting in Quebec

The twenty-seventh annual meeting of the A.N.P.Q. was held in the Windsor Hotel, Montreal, May 26-27, 1947. The first morning session featured reports from the eleven district associations, three of which contain two chapters organized on a language basis. Lunch with the Committee of Management followed the morning session. This was entirely informal and friendly and there were no speakers.

At 2:30 p.m. the general meeting was called to order by the president, Miss E. C. Flanagan, and officially opened by Dr. Vidal speaking for the provincial Minister of Health. Dr. Vidal delivered a stirring appeal on behalf of the campaign to eradicate tuberculosis and emphasized the need for more co-operation on the part of the nurses of our province. Dr. Marc Trudel, president of the College of Physicians and Surgeons of the Province of Quebec, and Dr. Adélard Groulx, director of the Montreal Department of Health, welcomed the delegates.

Miss Flanagan and the Rev. Sisiter Valérie de la Sagesse responded to the addresses of welcome, following which a special vote of thanks was unanimously extended to Miss Flanagan on behalf of her services to the association, which she has served as president during the past seven years. In her presidential address which followed, Miss Flanagan presented a challenge and outlined the individual nurse's responsibility in regard to future professional developments.

The reports of officers, sections, and special committees, having been produced in folio form and distributed among the members, greatly facilitated matters, saved time, and promoted interest generally. The Committee on Legislation, under Miss Flanagan's chairmanship, presented proposed amendments to the association's by-laws, which bring them into line with the requirements of the new licensing Act. Miss Vera Graham, as chairman of the Committee on Auxiliary Nursing Workers, reported that a Bill to cover the preparation and service of all auxiliary nursing workers is in course of preparation. Refresher courses and special studies were reported by the Hospital and School of Nursing and Public Health Sections. There were no reports from the General Nursing Section.

The presentation and adoption of further reports, including the Official School Visitors, Board of Examiners, Committees on Labor Relations and Health Insurance, together with the report of the secretary-registrar, filled the agenda during the evening session.

The attendance at these two business sessions was only fairly good—not good enough if the problems of the day are to be solved and the difficulties of our time are to be overcome. The average nurse continues to move in a state of apathy—so long as there is a "George" to do things.

As is customary, programs covering the second day were arranged by the two language groups to meet their specific interests and needs. The English members concentrated on "Polio" in the afternoon, when Dr. H. B. Cushing discussed "The Early Aspects of Poliomyelitis" and Dr. W. G. Breckenridge "Later Aspects of Poliomyelitis and Other Orthopedic Treatments."

Following this session a buffet supper meeting brought together the directors of nursing and members of the Examining Board, the discussion being on "Special Services in the School Curriculum and Student Affiliation." Miss Kathleen Connor, of Alberta, gave a brief outline of the plan for affiliations in Alberta, which was greatly appreciated. A follow-up of the healthy discussion which took place at this meeting will be presented during a similar meeting to be held early in the fall.

In the evening we conducted a forum on "Labor Legislation as it Affects Nurses"—the speakers being Miss J. Elise Gordon, editor of the *Nursing Mirror*; Miss Kathleen Connor, chairman, Committee on Labor Relations, C.N.A.; Mr. Roger Ouimet, K.C., legal adviser to the A.N.P.Q. In the absence of M. Bihet, president, Belgium Nurses' Association, who had planned to be present, Miss Suzanne Giroux read a report covering the situation in Belgium, which Mlle Bihet had prepared.

French programs included (a) a round table discussion on polio, the speakers being Dr. A. R. Foley, provincial Department of Health and Welfare; Dr. Paul Larivière, pediatrician, Hôpital Ste-Justine; M. P. Savoie and M. Daigle; (b) an excellent address by Maître Jacques Perreault, of the University of Mont-

real, entitled "La Profession et le devoir professionnel"; (c) forum on industrial nursing, with the following speakers: Dr. F. J. Tourangeau, director of the Division of Industrial Hygiene, provincial Department of Health and Welfare; Dr. Graham Ross, director of Health Services, National Breweries; Dr. C. A. Bourdon, officer in charge of the Health Districts, Montreal Department of Health; Mr. Roméo Desjardins, director of personnel, Catelli Limited; A. Rita Guimont and M. St-Onge, industrial nurses; Mlle Alice Girard, director of the School of Public Health Nursing, University of Montreal and director of nursing services, Metropolitan Life Insurance Company in Canada, summarized the discussion. A special session, held on the morning of May 28, provided further opportunity for discussion when, under the chairmanship of the Rev. Soeur Denise Lefebvre, the working schedule and vacation for student nurses were discussed by four sisters, directors of schools. L'Abbé Llewellyn, aumonier to students at the University of Montreal, addressed the meeting on "The Problems of Educating Youth."

The results of the elections to the Committee of Management were announced, thus recording for the first time, and in line with the provisions of our compulsory licensing Act, a committee of twenty-four persons elected by the members of their district as-

sociations one month previous to the annual meeting. The committee is composed as follows:

Representing District Association: 1. Mlle Marie-Ange Chamard; 2. Rev. Sr. Marie Madeleine; 3. Mlle Ruth Aubin; 4. Rev. Sr. Normandin; 5. Mlle Alice Besner; 6. Mlle Madeleine Lacombe; 7. Rev. Sr. Jean des Lys; 8. Mlle Alma Benoit; 9. Rev. Sr. St-Ferdinand, Mlles Geneviève Lamarre, Marguerite Hébert, Miss Mae E. Lunam; 10. Mlle Lauréanne Couet; 11. Misses Fanny Munroe, Mary S. Mathewson, C. V. Barrett, Ethel B. Cooke, Rev. Sr. M. Felicitas, Miss Electa MacLennan, Rev. Sr. Allard, Rev. Sr. Valérie de la Sagesse, Mlles A. Martineau, Alice Girard, Marie Cantin.

The newly-elected Committee of Management, in accordance with the by-laws, appointed from among their number the following officers, who constitute the Executive Council: President, Rév. Soeur Valérie de la Sagesse; English vice-presidents, Mary S. Mathewson, Caroline V. Barrett; French vice-presidents, Rév. Soeur St-Ferdinand, Mlle Annonciade Martineau; honorary secretary, Ethel B. Cooke; honorary treasurer, Marie Cantin; councillors, the representatives from districts 1-5 inclusive.

E. Frances Upton, Secretary-Registrar Association of Nurses, Province of Quebec.

Nursing Sisters' Association

Mr. and Mrs. Hugh McLaughlin opened their home on Valleyview Avenue recently for a garden party, sponsored by the *Toronto Unit*, in aid of the British Nurses Relief Fund, when over two hundred guests attended.

Col. Agnes Neill received with her sister, Mrs. McLaughlin, and the president, Ethel Greenwood. Assisting with the serving were Mmes E. U. Mitchell, G. Storey, J. Bell, G. Hanna, C. Farquharson, M. I. Turner, Misses F. Charlton, D. Kent, H. Lane, D. Macham, E. Cleland, P. Black, B. Wright, D. Houghtling, and M. Kennedy. Hélen Howe was the garden party convener with Mmes Harry Coles and Harry Nixon conveners for the afternoon tea.

Maude Wilkinson and Mrs. H. G. Henson were in charge of "White Elephants," Isobel

McEwen of home baking, Jessie Goodman of teacup reading, and Mary McNaughton of raffles.

Members of the unit entertained delegates and nurses who were in Toronto in May and June for refresher courses at the University of Toronto School of Nursing, following the I.C.N. Congress. Mrs. George Hanna took her guests to the May Day celebration at Ontario Ladies' College, Whitby, and to dinner at her home. Mrs. William Black and Ethel Greenwood entertained at tea at the Royal Canadian Yacht Club for ten guests who represented five nationalities. F. Charlton and P. Black assisted. Mary Sunley had an English nurse as her house guest for ten days and Jean Taylor drove visitors about the city.

Nursing Profiles

Editor's Note: In the three years during which these special pages have been featured, we have endeavored to present a cross-section of the nursing personnel in Canada who are shaping the future of nursing or who have made noteworthy contributions through the years. It is inevitable that in the limited scope of these columns, only a sprinkling of personalities can be reflected.

So many of the nurses have a profound modesty about their own accomplishments that it has been deemed advisable to change the name of this page. In embarrassment, these hard-working, capable women have said, "But I am not interesting!" We hope the new title will remove any feeling of constraint our worthy colleagues may have in the future. How do you like the new caption?

Isabel Maitland Stewart, M.A., who for the past forty years has guided students of nursing in the School at Teachers College, Columbia University, has retired.

Fourth in a family of nine, the children of a Presbyterian minister, Miss Stewart was reared in the ideals of service and altruism. She came naturally by her most dominant qualities of character which, although forceful and impregnated with convictions, are acutely understanding and charitable in their nature. An intelligent student, a clear and logical thinker with a pioneering and adventurous spirit, an idealist, an almost selfless worker, Miss Stewart's rare sense of humor has helped her to sustain an even balance when other less resolute souls might have



ISABEL M. STEWART

wavered. Her consideration for the inadequacies of others, while maintaining the highest ideals of achievement for herself, have made her a unique personality; for rather than blame or criticize, she has often shouldered the responsibility of making the imperfect productions of others more perfect, burning the midnight oil in its accomplishment.

Prior to entering the school of nursing of the Winnipeg General Hospital in 1900, Miss Stewart had taught in the rural public schools of Manitoba for several years. Following graduation, she engaged in private duty for a period. Her interest in education led her toward broader fields and in 1907 she enrolled as a student at Teachers College to prepare herself as a teacher of nurses, planning to return to Winnipeg.

Fate decreed otherwise! Offered a position on the faculty of Teachers College, Miss Stewart remained in New York to begin the career in which she has so brilliantly succeeded. When she followed Miss Adelaide Nutting as director of the School of Nursing Education in 1925, the nursing profession both in Canada and the United States was in happy accord with her appointment.

The need of creating some organization by which an evaluation could be made of the status of schools of nursing was recognized by Miss Stewart, her idea finally culminating in the Committee on the Grading of Nursing Schools. Curriculum planning was then a logical step. Her vision and insight led to the formation of the Association of Collegiate Schools of Nursing.

World-wide leadership in nursing education has been given through Miss Stewart's activities in the I.C.N. As chairman of the Education Committee, she has made a very marked and permanent contribution to nursing in all of the member countries.

Miss Stewart's writings have been numerous and far-reaching. Her most recent publication was "The Education of Nurses," a volume of incalculable value.

Miss Stewart plans to travel, to keep in touch with nursing developments in different countries, and to enjoy the leisure which her busy life has so long denied her. The nurses of Canada, including especially the large number who have studied under her guidance at Columbia, wish her long years of happiness.

Marion (Stillwell) Bates, who graduated from the Toronto General Hospital in 1923, has been appointed dean of women at Mc-Master University, Hamilton. Mrs. Bates received her Bachelor of Arts degree from McMaster in 1920. She received a scholarship upon graduation from T.G.H. and spent the following year studying teaching in schools of nursing at the McGill School for Graduate Nurses. After a year as instructor at T.G.H., fate in the form of the late Dr. J. Edgar Bates intervened. Mrs. Bates has two daughters.

Mrs. Bates has been active in hospital work, home and school associations, and the missionary societies of the Baptist Convention of Ontario and Quebec. For four years she was editor of the Baptist Women's Missionary paper. This past summer, Mrs. Bates attended the Baptist World Alliance Meeting in Denmark.

In her new duties, Mrs. Bates will have a minimum of instructional responsibility, thus providing time for her active personal work with the women students.

Dorothy Forsythe Ballantine, A.R.R.C., matron-in-chief of the R.C.A. M.C., graduated from the Winnipeg General Hospital in 1930. Upon graduation, she joined the staff of the Prince Albert Sanatorium. Three years later, after a post-graduate course in operating-room technique Miss Ballantine became operating-room supervisor at Victoria Hospital, Prince Albert. In 1936, she joined the neurosurgical nursing department of St. Mary's Hospital, Rochester, Minn., and two years after was made operating-room supervisor at Touro Infirmary, New Orleans.

Enlisting in 1941, Miss Ballantine served overseas with No. 8 Canadian General Hospital and No. 2 Casualty Clearing Station.



Ashley & Crappen, Toronto

MARION BATES

She was principal matron of Canadian General Hospitals in both northwest Europe and England prior to her appointment as assistant to the matron-in-chief in Canada.

A very busy person, Major Ballantine's favorite relaxation is found in reading, particularly in the study of history.

The hundreds of students who have been guided by her since 1939 will always remember the kindly interest and enthusiasm with which Elsie Allder watched over them. Miss Allder has given up her position as head of the instruction department at the Royal Victoria Hospital, Montreal, and has undertaken new work in the Registrar's department of the Montreal Neurological Institute.

Graduating from high school in Woodstock, N.B., Miss Allder commenced her training at R.V.H. in 1918. She holds her certificate in teaching and supervision from the McGill School for Graduate Nurses. Except for a brief year when she served as school nurse at a private school for boys in Connecticut, all of Miss Allder's professional activity has been devoted to her alma mater. In addition to her work as instructor, she has been supervisor in surgical wards, the outpatient department, obstetrical, and medical departments.

Miss Allder has been active in the provincial association and alumnae work. She served two years as president of the R.V.H. alumnae and two years as president of the alumnae of the McGill School.

Mary Lillian Shepherd, superintendent of nurses of the Winnipeg Municipal Hos-



Gauvin-Gentzel, Winnipeg

MARY L. SHEPHERD

pitals, graduated from the Winnipeg General Hospital in 1928. After a very brief experience in private duty nursing, Miss Shepherd joined the staff of the Municipal Hospitals. In 1937, she became charge nurse on a ward; then served as admitting and operating-room nurse, supervisor, instructor and assistant superintendent to her present position.

Miss Shepherd is exceedingly interested in people. She has a very wide range of correspondents all over the world. Her hobby is her camera and the thousands of snapshots, all neatly fastened in albums and labelled, bear mute testimony to her methodical interest. Camping, tennis, swimming provide her outdoor activities. Miss Shepherd is first vice-president of the W.G.H. alumnae association.

The campaign for Canadian aid to China has been pointed up by a letter from one of our Canadian nurses who was serving with UNRRA in China. Muriel Jean Graham, who for many years was registrar, treasurer and corresponding secretary of the Registered Nurses' Association of Nova Scotia, and who spent nearly four years overseas with the R.C.A.M.C., upon her discharge offered her services to UNRRA. Miss Graham was well qualified for the difficult tasks which confronted her.

A graduate in Arts from St. Francis Xavier University, Antigonish, Miss Graham received her training from the Victoria General Hospital, Halifax, graduating in 1932. The following year she received her certificate in teaching and supervision in schools of nursing from the McGill School for Graduate Nurses. After a year in private duty nursing she joined the provincial office of the R.N.A.N.S.

After a long, tedious journey, Miss Graham reached China and began her new work of organizing nursing programs and caring for undernourished natives. Recently she was transferred to the island of Pingtung where, with the aid of a young Chinese nurse to act as interpreter, she assisted the Chinese doctors in rehabilitating the hospital, organizing a modern nursing service, and conducting a short course for nurses. All of the problems attendant on finding living quarters, demonstration and classrooms and every kind of supply had to be met. When the World Health Organization takes over the responsibility for this work, Miss Graham expects to return to Canada. The fine example which she has set may well serve to inspire other nurses to help in providing aid to China.

Mabel Dubbin who, since 1914, has been on the staff of the Victorian Order of Nurses for Canada, serving in the Whitney Pier District of the Sydney (N.S.) branch, has retired.

Born in London, Eng., Miss Dubbin took her children's training in Dr. Barnardo's Home in Babies' Castle, Hawkhurst, Kent, England, and left there for West Middlesex County Hospital, Isleworth. On completion of that training, she took a six-month midwifery training in the same hospital, passing examinations for Central Midwives Board. After leaving there she joined Her Royal Highness Christian Nurses Home and completed three years' private nursing.

Miss Dubbin devoted her life to the people she worked with, not only nursing their ills, dealing with health problems and home conditions, but spending evenings in clubs and classes which she organized for their benefit. She was an ever present friend in their midst, and will long live in the hearts of the people of the Pier District. Before leaving Sydney, Miss Dubbin received many tangible expressions of appreciation from the board, the doctors, the nurses and the people in the community.

Miss Dubbin plans to reside in Kelowna, B.C., with her brother, where she will have her own little home on his ranch "Annicedale." She plans to have a flower garden and raise some chickens, and in her leisure time to write a book telling of her many interesting experiences since coming to Canada.

Agnes Cox has retired after forty years of nursing, the past twenty-five of which she has served in the Halifax Tuberculosis Hospital where she was appointed matron in 1936. Miss Cox graduated from the Victoria General Hospital, Halifax, in 1907. After two years at Highland View Hospital, Amherst, she felt the lure of the west and spent three years in hospitals in Alberta and Manitoba. Returning to Nova Scotia, Miss Cox nursed in Sydney and Halifax and was two years on the staff of the Victorian Order of Nurses, before joining the hospital.

A dinner was held in Miss Cox's honor, when her retirement was announced, in recognition of her long and notable record in nursing. An illuminated address and gifts were presented to Miss Cox. Her many friends extend best wishes for many years of well merited rest and happiness.

Gertrude M. Kilpatrick, who has been superintendent at Soldiers' Memorial Hospital, Orillia, Ont., has resigned to be married. Graduating from the Toronto General Hospital in 1925, Miss Kilpatrick took a short



GERTRUDE KILPATRICK

course in administration at the University of Toronto School of Nursing. Her professional life has been spent chiefly in Orillia.

Industrial Dusts Can be Poisonous

Certain toxic (poisonous) metal dusts and organic liquids are common in industry, and there are actual maximum amounts beyond which average persons, chronically exposed, cannot safely inhale daily in the form of floating dust or vapor.

For instance, no worker should inhale daily more than about 10 milligrams of silica or more than one gram of benzol. Incidentally, there are 1,000 milligrams in one gram, and seven grams in one teaspoonful.

Other materials and quantities in the list: Lead (and its salts): about 1.5 milligrams. Mercury (and its salts): about 1 milligram. Cadium (and its salts): about 1 milligram. Radium (and its salts): about one millionth of a milligram.

Carbon Disulphide: about 200 milligrams.

Methanol: about 500 milligrams.

Carbon Tetrachloride: about 1 gram.

Aniline: about 100 milligrams.
Butvl Acetate: about 1,700 milligrams.

Nitrobenzene: about 600 milligrams.

(The above information was obtained through the courtesy of the Industrial Hygiene Division of the Ontario Department of Health.)

This month, the new subscription rate for the Journal becomes effective. The remarkable increase in the total paid circulation during the past five years - from 4,316 in September 1942, to 9,818 in September, 1947 - is abundant proof of the confidence the nurses of Canada have in their own nursing magazine. There is ample room for a repetition of this growth during the next five years. Every province shares in the interest, and the responsibility, for this development. The actual circulation, by provinces, as at September 1, 1947, was as follows: Alberta, 809; British Columbia, 1,204; Manitoba, 557; New Brunswick, 607; Nova Scotia, 590; Ontario, 3,408; Prince Edward Island, 143; Quebec, 1.047; Saskatchewan, 641.

STUDENT NURSES PAGE

Traumatic Laceration of the Ileum

ANITA LIVIS

Student Nurse, School of Nursing, Woodstock General Hospital, Ont.

Young Jimmy was admitted in his father's arms to the children's ward of the Woodstock General Hospital on July 28. He was two and a half years old, and one was immediately struck with admiration for his finely featured face, and almost platinum hair—very closely cropped, or what we commonly term "a brush cut." There was no struggle against being undressed and put in a cot, which is quite unusual for a child in a sick condition. Jimmy appeared somewhat stunned and lay placidly in bed, allowing his nurse to continue her duties. At first glance, a few abdominal abrasions were seen, these being slightly to the left of the umbilicus. Further visual examination showed minor scratches on his left leg and toes, but other than these there were no marks over his entire body. On admission at 9:30 p.m. Jimmy's pulse was 120, but of very good volume and regular beat. His respirations were of a grunting nature, but were only 26 to the minute.

The history received from Jimmy's parents, before they left the hospital, was very scanty. They lived on a farm about one mile outside the city limits, and had ten living children. Both parents were acutely concerned over Jimmy, and one was impressed with the fact that here was a family very closely knit and loved. Mr. M. explained that on that afternoon Jimmy had been riding with him in a rig drawn by a horse. The rig was jolted while moving, and Jimmy, who

was standing up at the time, fell to the field, face down. A doctor was consulted, and he advised hospitalization.

An order for phenobarbital ½ gr. was given, should it be necessary to quiet any restlessness and induce sleep, but Jimmy slept right through his first night in hospital. His pulse and respirations slightly increased and by morning his temperature was 1012 (r), pulse 132, and respirations 30. X-ray films of his abdomen were taken, and the report was of little help in the doctor's diagnosis—"there was no evidence of free air in the peritoneal cavity." Under ordinary circumstances this would have meant that there was no escape of air from an open portion of the intestines.

After consultation between Dr. R, the surgeon, Dr. B, the attending physician, and Dr. L, the radiologist, it was decided that immediate surgery was advisable, in consideration of a rising pulse rate and a high white blood count. Jimmy, still in a stunned condition, was taken to the operating-room at 10:25 a.m. on July 29. Summarizing his pre-operative diagnosis Dr. B had written "acute abdomen with possible perforated bowel."

The anesthetic used was cyclopropane, a gaseous compound. Much praise may be given this type of induction. It is not sufficient just to relieve a patient of pain. All the muscles must be well relaxed in order to rule out fatigue and shock. The patient's recovery from anesthetic

must be free of complications that in any way may interfere with his convalescence. Cyclopropane covers all these factors, with uncomplicating results. This gas possesses the properties of rapid induction and recovery. It is non-irritating to the mucous membrane of lung tissue. It does not stimulate respirations. Finally, there is no fear of cyanosis, because of its

large oxygen content.

The operation began at 11:35 a.m. and a left paramedian incision was made, opposite the umbilicus. Jimmy's fall, with only a few scratches and bruises on the skin surface, had indeed produced a condition, the prognosis of which depended on surgery. The x-ray report had read that there was no free air in the peritoneal cavity, which suggested that the injury had not cut the bowel. surgeon found, however, an almost completely severed bowel in the ileum region. This might well contradict the x-ray findings but where, ordinarily, air caused by peristaltic action would have escaped from the opening into the cavity, in this case shock had stopped all peristalsis, hence there was no free air in the abdomen. Both ends of the severed ileum were opened, but fortunately the peritoneum was soiled very little. There was contusion of the mesentery to the sigmoid. The wounded and lacerated bowel was excised and a primary anastomosis, or the establishment of a communication between the two open portions of the ileum, was done. For this, the surgeon used No. 00 chromic sutures. It is interesting to note the value of this chromic type of suture material. It is catgut which has been treated and resists absorption by the tissues for a longer period of time, and consequently approximation may extend from ten to twenty The incision was closed at 12:45 p.m. by the use of skin clips.

Jimmy returned to his cot in children's ward with an intravenous of normal saline running into a vein at the ankle; this cut down was done while he was still in the operating-room. His general condition was considered good and although his respira-

tory rate reached as high as 64, it gradually decreased to a normal 30 by 4:30 in the afternoon. At 1:35 p.m. after 350 cc. of the saline had been absorbed, a transfusion of citrated blood was started, and at 5:15 p.m. it too was completed. The sodium citrate method entails the addition to the blood of 10 cc. of 2% sodium citrate solution to each 100 cc. of blood. This makes it feasible to carry the blood from one part of the hospital to another without danger of coagulation and it may be kept for some time without being injected into

the recipient.

Sedative of morphine sulphate, gr. 1/16, by hypodermic was given to Jimmy at 1:50 p.m. and again at 5:30 p.m. Following the blood transfusion 5% dextrose in 1000 cc. of normal saline was started with one ampule of soluthiazole mixed in the solution. The drug soluthiazole is a solution of sodium salt of sulfathiazole. Each ampule of 5 cc. contains the equivalent of 15 grains of sulfathiazole. The soluthiazole is used in cases for which rapid and intensive action is necessary, and in cases where oral administration is impossible. This dosage was repeated twice, and the three administrations of blood, intravenous nourishment, and soluthiazole played a major role in Jimmy's post-operative condition. Nausea and vomiting were noted only twice, and that during the period when the morphia was taking its effect.

Mineral oil was given frequently in small doses, thus enabling the first bowel movement to be easy, with no strain on the sutured intestines. Jimmy's convalescence was a speedy and satisfactory one. It was during his convalescence that he became so well liked by his nurses. Intermingled with his sunny disposition was a keen sense of loneliness for his home and parents. He lived for the time each day when his mother and father would walk into the room, their arms filled with delightful gifts. His prize possession was a small car his father had given him, and we all admired it, if only to win his approval by so doing. Teaching him health habits was in-



ONTARIO DIVISION

CANADIAN RED CROSS SOCIETY

OUTPOST HOSPITAL SERVICE

Registered Nurses required for Floor Duty in small hospitals. Salary: \$115 per month plus full maintenance. Annual increases given.

Comfortable living accommodation. Hospitals located in Northern and North Western Ontario.

Nurses subject to transfer from post to post when directed by Head Office.

Travelling expenses paid. One month's holiday granted after one year's service, with half-fare; travelling expenses paid to nurse's home if in province. Return fares paid on leaving staff after one year or more service.

Public Health Nurses also needed. Salary: \$1,740 yearly plus maintenance, with annual increase.

For further information apply to: Canadian Red Cross Society 621 Jarvis St., Toronto 5, Ontario deed an easy task, and he enjoyed nothing better than scrubbing away at his teeth, even though his lips received most of the power behind his vigorous arm movements.

Jimmy's abdomen remained soft with no distention, and so his diet continued to increase. On August 6, seven days after his operation, the doctor removed the skin clips and found the incision was in excellent condition, having healed by first intention. The doctor felt that since Jimmy missed his home environment so acutely, and since there would be excellent care at his home, he could be discharged. On last inquiries, we learned that Jimmy was once again in normal health, playing happily about with his brothers and sisters—all ten of them.

Summarizing Jimmy's case, we find that the combined efforts of surgery, medicine, radiology, and nursing care all played in important part in his diagnosis, therapeutic reactions, and final recovery. From the time of Hippocrates to the present time, all the knowledge gathered by actual practice by our doctors and nurses continues to save and mend lives of such as our young Jimmy.

Book Reviews

Solutions and Dosage, by Sara Jamison, R.N., 295 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18. 1947. Illustrated. Price (in U.S.A.) \$2.50.

Reviewed by Anne Carpenter, Science Instructor, Winnipeg General Hospital School of Nursing.

In this text, which covers the arithmetical and practical skills involved in the preparation of solutions and dosage, Miss Jamison has attempted successfully to simplify for the student nurse the problem of gaining the necessary understanding and skills in this particular area of her preliminary course in drugs and solutions. There is deliberate

effort to follow the logical sequence of the student's progress in learning, from simpler concepts to more difficult ones.

The first forty pages provide an arithmetic pre-test and review. Then follow problems in the preparation of solutions, where there is an earnest endeavor to select examples from practical situations met within the hospital. Good illustrations of hospital measuring equipment are included. While both the apothecaries and metric systems are presented, and the approximate nature of equivalents between the two systems is stressed, the tendency throughout the text is toward the Metric system. Detachable arithmetic pre-test, and laboratory and review exercises are an interesting feature of the book.

For the student nurse this text furnishes a useful adjunct prior to her use of a pharmacology text in the study of drugs. For the instructor searching for clear and simple techniques in teaching arithmetical principles, it makes available a particularly useful tool.

Professional Adjustments I, by Alice L. Price, B.S., R.N. 212 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1946. Price \$2.00.

Reviewed by Helen M. McDonel, Educational Director, Winnipeg General Hospital School of Nursing.

In designing an aid in personal living, in and out of schools, the author has provided attractive clothing and pulsing life for such abstract concepts as ethics, morale, and tact.

Especial emphasis has been placed on clear-cut suggestions for proper methods of study; understanding of good manners; regulations for group living; care of property in the residence or hospital; and specific data regarding financial and legal responsibilities.

Of especial value are the provisions for increasing the student's vocabulary, and instruction concerning the relieving of mental and spiritual stress, without imposing her own religious views on the patients. Much of the context could be used in health courses if they are interwoven throughout the entire three-year curriculum.

Some helps I did not find in this reference are: Study of the adjustment of definite personalities, to serve as an anchor in a new environment; basic instruction in parliamentary



We're proud to say that from the very first we have made Baby's Own Toiletries especially for the care of the baby, as the name indicates.



Over 75 years of research and experience guarantee that only the purest and gentlest ingredients obtainable are used in the compounding of Baby's Own Toiletries.



Recommend with confidence

You can rest assured these high standards of purity and gentleness, worthy of your recommendation, will always be maintained in the preparation of Baby's Own Soap, Oil and Powder



The J. B. WILLIAMS CO. (CANADA) LIMITED

La Salle, Montreal

WANTED — ASSISTANT SUPERINTENDENT OF NURSES

A Graduate Nurse is required for the above position at the Manitoba School for Mentally Defective Persons, Portage la Prairie, Manitoba. Applicant should have had some Mental Hospital experience, and should be capable of teaching in the School of Nursing attached to this hospital.

Salary schedule: \$150 to \$175 per month, less \$25 for full maintenance — accommodation, meals, laundry and uniforms, etc.

This is a permanent position offering one month's vacation with pay annually, sick leave with pay, pension privileges, etc. For full particulars, apply immediately to:

MANITOBA CIVIL SERVICE COMMISSION 223 Legislative Building, Winnipeg

procedure which students may use in their organizations.

This type of friendly, "up-to-the-minute" counselling, written in an informal style, to meet successfully the standards of conduct today should be happily received by students.

White Caps, The Story of Nursing, by Victor Robinson, M.D. 425 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1946. Price \$4.25.

Reviewed by Rhoda F. MacDonald, Director, School of Nursing, Aberdeen Hospital, New Glasgow, N.S.

When I first glanced into this book, I thought—here are a lot of dry quotations and historic events to wade through. As I read, I became more and more interested. There were many phases of medical and nursing life that I had not read or heard of before and many nurses were mentioned whom I had not known had contributed so much to nursing history. The little excerpts were very vivid, entertaining, and enlightening. This book is very absorbing and instructive. It will be read by all nurses with pleasure and they cannot help but have a deeper appreciation of their profession after reading it. It should prove a great assistance to instructors in

schools of nursing, guiding students in their history of nursing study.

Dr. Robinson is an outstanding physician and author. He delivered many lectures on history of nursing to student nurses at several hospitals. In his book he has presented a picture of the start of the medical profession and traced nursing from its beginning to the present time. Especially interesting is the first chapter—Hospitals and Hospitality in Antiquity. This chapter is followed by interesting illustrations. The entire book is written in a most delightful manner, giving, in many instances, more detail regarding individual nurses than is usually found in most books on nursing history. The March of the Nurse, written in chronological form, the bibliographical notes, and the two final sections are of great interest and should prove very helpful to students, and will also be a good review for the graduate nurse.

Psychology Applied to Nursing, by L. A. Averill, Ph.D. and F. C. Kempf, R.N., B.S. 496 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 3rd Ed. 1946. Illustrated. Price \$3.00.

Reviewed by Mildred Nelson, Assistant

VOLUME 43 NUMBER 11 MONTREAL NOVEMBER 1947

CANADIAN NURSE



SHOCK THERAPY

Dr. W. J. Fisher

START TALKING!

Priscilla Campbell

Hospital Penicillin
Treatment Centre

Sister M. Décary



1 A HAPPY COUPLE

one lime Coprich



a 'wellcome' solution for a seasonal problem

The problem of relieving the nasal congestion associated with colds, sinusitis, and rhinitis can be effectively solved by application of 'Wellcome' brand Ephedrine Isotonic Solution (Aqueous).

It contains 1 per cent of Ephedrine in a modified Locke's Solution; a combination which offers four distinct advantages of comfort and benefit to patients:

- It has an immediate and prolonged effect of mucosal shrinkage.
- Unlike oily preparations and those containing various antiseptics, it does not impede ciliary function.
- 3. It is non-irritating.
- 4. Its application is not followed by after-congestion.

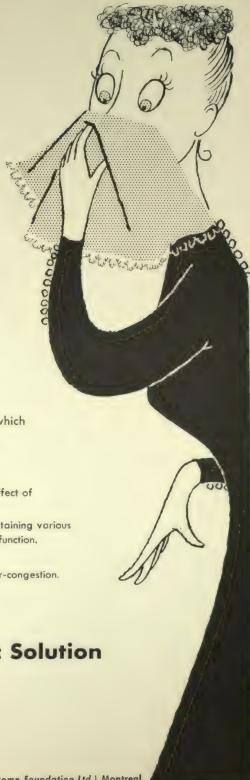
'Wellcome' brand

Ephedrine Isotonic Solution

(Aqueous)

Available in bottles of 1 fl. oz. (with a dropper) and 16 fl. oz.





The Medical Profession Can Recommend

HEINZ JUNIOR FOODS

For These Uses

- I. Feeding of babies beyond strained food age—
 - A. To supply coarser food that requires some chewing;
 - B. To furnish foods of high nutritive value;
 - C. To familiarize child with new flavors and tastes

II. For older children-

To furnish simple seasoned foods of high nutritive value at all times, and especially when the regular family diet is not suitable for children.

III. For adults on special diets-

A. Semi-soft diets:

Where the intake of coarse foods must be restricted, but a strict smooth diet is not required.

- B. Simple foods of good nutritive value for:
 - 1. Convalescents;
 - 2. Invalids;
 - 3. The aged.

IV. General family use-

- A. For table use;
- B. For soups and other special recipes.

Junior Foods Now Available

CHICKEN SOUP
LAMB AND LIVER
TOMATO AND RICE
MIXED VEGETABLES

CARROTS
SPINACH
GREEN BEANS
PRUNE PUDDING

VEGETABLE BEEF DINNER CREAMED DICED VEGETABLES PINEAPPLE RICE PUDDING APPLE, FIG AND DATE DESSERT

HEINZ STRAINED FOODS



HEINZ JUNIOR FOODS

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa.

Editor and Business Manager:

MARGARET E. KERR, M.A., R.N., Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

CONTENTS FOR NOVEMBER, 1947

CREATING RAPPORT	837
A Princess Weds	838
SHOCK THERAPY	.D. 839
START TALKING!	bell 844
Hospital Penicillin Treatment Centre	ary 847
Training Nursing Assistants	dell 851
TRENDS IN NURSING E. MacInt	losh 855
THE PUBLIC HEALTH NURSE AND MENTAL HYGIENE	.D. 861
Personnel Guidance	wles 863
L'Enseignement Chez les Malades	oux 866
Nursing Profiles.	868
Notes from National Office	871
Notes du Secrétariat de l'A.I.C.	873
A Model Nurses' Home	nce 875
FOOD POISONING	.D. 878
Bacterial Pericarditis	lbee 881
Book Reviews.	888
Venue Morne	906

Subscription Rates: \$3.00 per year — \$5.00 for 2 years: Foreign & U.S.A., \$3.50; Student Nurses, \$2.00 per year — \$5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address. Four weeks advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of month preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.



NOVEMBER, 1947

Reader's Guide

During the past twelve months, your editor has been privileged to visit every province in Canada and to speak to thousands of nurses. This form of contact is exceedingly valuable in building up a larger and more aware group of subscribers and readers. It is even more worthwhile because of the opportunities thus afforded to meet future authors of Journal articles, to interest the nurses who are giving the care in our hospitals, who are making the visits in the homes, to describe their work for us. One very gratifying result of these tours, therefore, will be the steady flow of articles on new and different topics which will be published in the months to come.

Another practical and advantageous result of these visits has been the acceptance by scores of superintendents of nursing of the proposal that the Journal be regarded as a required text for student nurses. We are all aware of the relative ignorance of many of our young graduates regarding the activities and accomplishments of their professional organizations. The most propitious time to foster this interest is during the undergraduate period as an integral part of the whole learning process. This has always been the philosophy of the Executive Committee in its provision of a special subscription rate for the Journal. To further this purpose, series of questions based on the articles in the Journal are prepared every three months and will be distributed on request. The study of these questions would form a useful topic for chapter meetings also. Write us if you would like to receive copies.

Dr. Walter J. Fisher has given us a very detailed description of the reactions which may be expected from the various forms of shock therapy which are being practised today in the treatment of mental illness. Dr. Fisher is a neuro-psychiatrist in Saint John, N.B.

Penicillin is being used in such enormous quantities in our hospitals today, that the

mere physical task of administering the required dosage at properly spaced intervals looms as an important factor in assigning ward duties. The program which has been described for us by **Sister M. Décary** should assist considerably in lightening this task. Sister Décary, who was formerly director of nursing at Notre Dame Hospital, Montreal, now occupies a similar position in St. Peter's Hospital, New Brunswick, N.J.

Priscilla Campbell, administrator of the Public General Hospital, Chatham, Ont., has made an enviable name for herself in rousing and maintaining public interest in nursing. Her personal scrap-books are filled with hundreds of newspaper clippings—mute evidence of her ability. She has excellent ideas.

So that you may be familiar with some of the present-day trends in nursing when you launch your publicity programs, we are pleased to bring you the thoughtful analysis prepared by Eleanor MacIntosh. This material was presented to the staff nurses meeting at Toronto Western Hospital where Miss MacIntosh was engaged as science instructor. She is now on the staff of the School of Nursing, University of Alberta.

Dr. Charles H. Gundry is the director of School Health Services, Division of Mental Hygiene, with the Metropolitan Health Committee, Vancouver. Mary Rowles has had a wide experience in many branches of nursing service. You will remember her as winner of the first prize in our 1946 article contest. At the present time she is industrial nurse with the Dominion Glass Co. Ltd., Redcliff, Alta.

Dorothy G. Riddell, inspector of Training Schools with the Ontario Department of Health, Nurse Registration Branch, provides us with a comprehensive picture of the organization and program of training for the nursing assistants in Ontario.

Canadian Nurses' War Memorial

When any one of you is asked to give a lecture or group of lectures on any nursing subject, what is one of the first things you do? Is it not to gather around you the latest nursing textbooks and journals and from these

and your own personal knowledge and experience draft your lecture or lectures?

The necessary books are easily collected—your school of nursing libraries will provide
(Please turn to page 870)

Behind the Label...



In the ultra-modern Bayer Laboratories Aspirin is made with infinite care, and under the most exacting scientific controls, In all, seventy different tests and inspections are employed to insure the quality, uniformity, purity and fast disintegration for which Aspirin tablets are famous. And behind these controls are 46 years of experience in making this best-known of all analgesics.

"ASPIRIN"
The analgesic for home use

Aspirin is the registered trademark in Canada of the Bayer Company Limited

NOVEMBER, 1917 829



WHY R.N.S FREQUENTLY

RECOMMEND TAMPAX

Because they have personally found TAMPAX so uniquely comfortable, safe, 1.2.3.4. adequate and dainty—nurses frequently suggest the use of this internal menstrual guard to their patients. Secure in the knowledge that their recommendations have wide professional endorsement, they are glad to introduce this intravaginal tampon to all women of menstrual age.

- For more than ten years, progressive nurses in hospitals, in private duty work and in industry have highly favored TAMPAX for its obvious advantages. During the war, and since, the U.S. Army and Navy have purchased TAMPAX for nurses in the various theatres. And now young women just starting their careers are being taught the TAMPAX method in numerous nursing schools throughout the country.
- Three absorbencies of TAMPAX (Regular, Super, Junior) are available to meet individual requirements. Professional supplies freely available.

1. J.A.M.A., 128:490, 1945.

2. Am. J. Obst. & Gyn., 48:510, 1944.

Am. J. Obst. & Gyn., 46:259, 1943.
 West. J. Surg. Obst. & Gyn., 51:150, 1943.

TAMPAX

THE INTERNAL MENSTRUAL GUARD OF CHOICE
ACCEPTED FOR ADVERTISING BY THE JOURNAL
OF THE AMERICAN MEDICAL ASSOCIATION



CANADIAN	TAMPAX	CORPORATION LT	D
	Brampton,	Ontario	

- Send literature and professional samples
- Send educational material for.....students

Vame

(Please Print

Address

City Prot . P7.31

831



"My course in skin care taught me about the little blue jar"

Like most student nurses, I had to be taught proper skin care. And the first thing I learned was something scores of nurses have known for years...to use the Medicated Skin Cream, NOXZEMA for such common skin discomferts as rough, red, chapped hands, tired, burning feet and externally-caused skin blemishes.

Then I started using NOXZEMA as a night cream. It's greaseless, stainless, and helps make my skin feel wonderfully soft and smooth.

Now I'm using it as a powder base under make-up -- it helps smooth my complexion just the way it does red rough hands! In fact, NOXZEMA is "a regular beauty course" in a little blue 'ar!

Uniforms look fresher...stay cleaner ... with DRAX*

the amazing fabric rinse that gives a like-new finish . . . resist dirt and soil!



There's nothing like DRAX! Not a starch...not a soap...DRAX is a wonderful new way to give uniforms a sparkling fresh finish... and help them stay cleaner and crisper-looking far longer!

DRAX... made by the makers of Johnson's Wax... is actually an invisible wax rinse that guards the fabric from dirt and soil. It helps restore the new look of the fabric and

give it a soft, fresh finish that makes the dirt slide off, makes the fabric easier to wash and easier to iron! You cut laundering costs when you use DRAX. Uniforms . . . curtains, bedspreads... all washable fabrics need laundering less often and launder more easily when they are DRAX-protected! You'll want to find out how DRAX can save you money . . . today!

DRAX is made by the makers of Johnson's Wax

(a name everyone knovs)

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

D-147

THAT MAKE HIS AND A PAT HE

NOVEMBER, 1947 843





150 years ago, Americans believed that the black spot in the flower Euphrasia—eyebright—could be applied to diseases of the eye.

It was also believed that, since the nutmeg somewhat resembled the brain, it was effective in treating diseases of the brain!



Many mothers think that canned foods that have been frozen are not edible. This is not true.

Some foods may change in appearance or consistency by freezing, but food value is unaffected. Many delicious desserts are made from frozen canned food.



A M E R I C A N C A N C O M P A N Y
KENTYILLE MONTREAL HAMILTON TORONTO WINNIPEG VANCOUVER

Now available on request—
"THE CANNED FOOD
REFERENCE MANUAL"

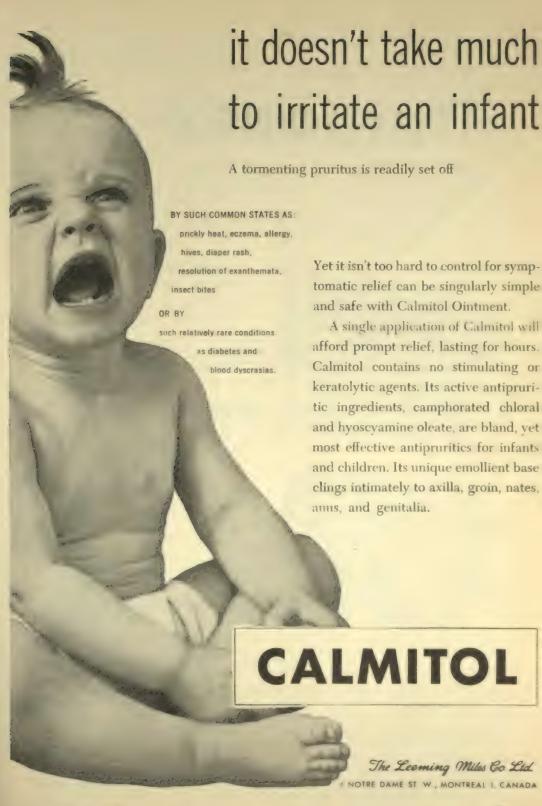
—a handy source of valuable dietary information. Please fill in and mail the attached coupon now.

834

CANNED FOOD IS GRAND FOOD

AMERICAN CAN COMPANY
92 King Street East, Hamilton, Ont.
Please send me the new Canadian edition of "THE CANNED FOOD REFERENCE MANUAL," which is free.
Name
Professional Title
Address
City Province

Vol. 43, No. 11

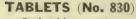


NOVEMBER 1945 835

IN SECONDARY ANAEMIAS

THIRONEX'

IRON EXTRACT LIVER VITAMIN B FACTORS



Each tablet contains:

Ferrous Sulphate Exsiccated 162 mg. (2.5 grains) Liver Concentrate - - equivalent to

1 Gm. fresh liver 1 mg. 0.66 mg.

3.34 mg. 0.34 mg. Calcium d-Pantothenate 1.84 mg.

In bottles of 100, 500 and 1000



SYRUP (No. 944)

Each millilitre contains:

Ferrous Chloride

30 mg. (0.468 gr.) (Citrated) Copper Sulphate 0.228 mg. (0.003 gr.)

Liver Concentrate - equivalent to 0.246 Gm. fresh liver Thiamin Chloride - 0.029 mg. Riboflavin - - 0.038 mg. Niacinamide - 0.475 mg.

In bottles of 16 ounces



MCKENNA & HARRISON LIMITED AYERST.

Biological and Pharmaceutical Chemists

CANADA

446

MONTREAL

Vol. 43, No. 11

1. 1. 18

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED. BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER ELEVEN

MONTREAL, NOVEMBER, 1947

Creating Rapport

EVERY NURSE working in any hospital today is closely, personally, familiar with the feeling of rush and urgency that busy wards and too few pairs of trained hands has precipitated. Every nurse giving bedside nursing care in the homes is aware of the amount of work ahead of her which must be accomplished in as short a time as possible so that other jobs may also be fitted into a day's work. Every nurse engaged in other aspects of community health work is similarly conscious of the driving force which is the inevitable accompaniment of the present-day so-called nurse shortage. There is no magic formula which can reduce all this hurly-burly to a simple problem which any one of us can solve individually.

At this time it may help matters somewhat if we pause long enough to adjust our thinking to the patient's point of view. What does it feel like to be one of the focal points of this mad whirl? How can the nurse successfully reach the patient and convince him that he, as an individual, is important.

The primary factor which every nurse, be she student or graduate, must strive to develop, the axis about which her various duties revolve, is the relationship which she is able to establish with the patients. In order to facilitate an agreeable and satisfactory rapport, it is necessary for each nurse to understand the basic concept, which is her attitude to the people whom she is serving.

The advantages of creating good rapport have long been recognized, especially in modern hospitals for the care of the mentally ill. Perhaps there more than elsewhere rapport is stressed as a cogent factor in recovery. It can be applied with equal value and significance in every nurse's work.

Let us, therefore, examine the qualities, the attitudes, which are essential to the creation of a smoothly-functioning rapport. Rapport is the communication, the relationship which exists between two individuals. No hard and fast rules may be laid down as to how it may be built up. Each nurse must follow her own personal pattern. The following qualities are

NOVEMBER, 1947 837

inherent in its development. Conscious attention to the development of these attitudes will work wonders.

Courtesy and tactfulness, which are closely allied and are necessary for agreeable relationships with all people, but particularly with those who are ill.

Friendliness, which embraces confidence and hospitality.

Patience, which when it is real is translated into interest.

Truthfulness, best demonstrated by earnestness of manner and sincerity of purpose.

Even temper, which is absolutely essential when dealing with those who

are emotionally upset.

Non-critical attitude, which is best shown by the ability to refrain from making unkind remarks about the

patient's idiosyncracies.

Poise, displayed by the absence of a sense of superiority, by calm gentleness instead of excited rushing about, by the avoidance of words of anger even in the face of trying ex-

periences.

While every nurse must ultimately work out her own technique for creating rapport, each time it is successfully achieved the method will become more sure and involuntary. Having established rapport, the wise nurse will ensure that no act or word of hers will destroy it and thus undermine the patient's confidence in her. She should deliberately determine that her business in life is to exercise a constructive influence on her patients. Their restoration to health and their subsequent regard for nurses and nursing depends to a

very considerable extent upon the rapport that each individual nurse is able to create. Thus, she is not only building a sound reputation for herself, she is strengthening the status of the whole profession of nursing — a worthwhile contribution.

What proof have we of the results of successfully-created rapport? Every hospital receives letters expressing gratitude, not only for the care that has been given but also, indirectly, for the rapport that was established. The following excerpts from a letter we have just received illustrates the point most graphically:

May I request you to insert my "Vote of Thanks" in your nurses' magazine.

I was on a recent visit to relatives when unforeseen circumstances made it necessary for me to undergo an immediate operation. The nearest hospital was in T where I consulted Dr. R, surgeon. His approach was one of kindly interest so I decided (in spite of my fears) to place myself in his hands.

I was so well cared for and also shown such real consideration by the hospital staff that I feel they deserve an appreciative acknowledgment.

Having taught school for forty-four years and enjoyed the lion's share of kindness and understanding, I feel I owe this public acknowledgment to the members of the hospital staff.

I am, Yours gratefully,

Mrs. F. S.

Good public relations are vitally important. Creating an easy rapport is the first step in building public appreciation, understanding, and eventual support. It is worthwhile.

— M.E.K.

A Princess Weds

NOVEMBER 20, 1947, will be a gala day in Britain in spite of the austerity demands which circumstances have forced upon a gallant people. Not only in Britain but throughout the Commonwealth and

the world, millions of people in all walks of life will pause briefly and silently breathe a prayer for her happiness as Her Royal Highness, Princess Elizabeth, is married. The evergrowing throng of nurses in Canada unite in adding their good wishes to

the mighty chorus.

The world has watched the steps in the training of a future queen with interest and admiration. The determination of her parents that she should enjoy a full, rich, care-free childhood; that, so far as was humanly possible in the midst of State duties and a full program of public engagements, the princesses should have a natural family life, has strengthened this pattern of living beyond any words. Princess Elizabeth's education has given her a breadth of knowledge and understanding befitting the responsibilities of heiress presumptive to the British throne. She has also shown a great capacity for enjoying outdoor sports and activities.

As nurses, we are all aware of the sincere interest Princess Elizabeth has taken in the care of the sick, the wounded, the helpless. As president

of the Student Nurses' Association of the Royal College of Nursing, in Britain, she has closely identified herself with nursing activities. The sense of responsibility which has been implanted in her is reflected in the words which she spoke to the Empire on the occasion of her twenty-first birthday broadcast:

There is a motto which has been borne by many of my ancestors — a noble motto, "I serve." . . . I declare before you all that my whole life, whether it be long or short, shall be devoted to your service and to the service of the great imperial family to which we belong . . . God help me make good my vow, and God bless all of you who are willing to share it.

The nurses of Canada have a special reason, therefore, for taking the happy couple to their hearts and wishing them well in this their wedding month.

Shock Therapy

WALTER J. FISHER, M.D.

N RECENT YEARS the interest in psychiatry has steadily increased and, hand-in-hand with it, a widespread knowledge of the modern method of treatment. The laity is today aware of the term "shock therapy" and often when we are consulted, immediately the desire for the appliance of this "shock treatment" is expressed. Let us, therefore, examine what shock therapy is, when and how it is used, and what are its limitations. Mental diseases are not a modern invention, but may be as old as mankind. We find them mentioned through all the historical ages, and we find also mention in the olden times of some therapeutic manœuvres, gruesome and cruel, frightening and shocking. This means of helping the sick ones can certainly not be regarded as the predecessor of our modern shock therapy. The fundamental dif-

ference lies herein; our modern shock therapy acts when the patient is in an unconscious condition; the medieval treatments were applied only to a conscious patient. He was, therefore, treated on a psycho-therapeutic pattern.

When we speak today of shock therapy, we think first of insulin shock and, second, as somewhat opposed to it, of the convulsive therapy, divided into a pharmacologic convulsive treatment: the metrazol shock and the electric shock. As often seen in medicine, the space of a few years has brought forth a new way in therapeutics, approaching the goal from different angles. It is amazing also to see the way in which the men who made these discoveries found the conception of their ideas. Insulin was used for treatment in psychiatry long before. The idea was to raise the

weight of the excited patients and then to combat their excitement. The HC was carefully avoided and on this point Sakel recognized, with the gift of a genius, the importance of a phenomenon which became the central idea of his new treatment. Certainly many people could have seen, and saw, before Sakel, HC but they were not critical enough to visualize this

process.

In 1933 Sakel gave his first report at the University of Vienna, and although today some changes in the method of his treatment are made, the general idea has remained unchanged and the observations of Sakel can be regarded as classics. As our country has given the world insulin, you should all be familiar with the term HC. This means the appliance of insulin in such an amount that shock results. This dangerous shock, avoided before Sakel, is now the goal of the insulin shock therapy. You can easily understand that a patient cannot be brought carelessly to a shock condition. There is a definite technique which has to be followed.

As a rule, the insulin shock is given in a special ward. The carefully selected patients, whose temperatures are taken each day before treatment, start their treatment at 7:00 a.m., without having received breakfast. normal conditions, it is essential that a supervising physician and a supervising nurse with their full staff be present for the duration of the treatment which lasts four hours. This period is divided into special phases but, as reaction and complication may occur at any time, it is certainly wise not to leave the patients without supervision. We have our charts with the regular weight of the patients and with their temperatures. We do not treat febrile cases. Special care has to be given to the temperature and humidity in the treatment room, and also the beds should be chosen so that injury during the excitement of the patients can be kept at a minimum. It is the belief that undernourished patients and excited patients should not be excluded from the treatment.

Opinion is not unanimous about

the amount of insulin which should be used in order to produce a coma. Some doctors use as much as 1.000 units, whereas I never had to use more than 150, an amount which is approved by the greater number of physicians. We start with 20 units per day and increase slowly, about 8 units per day, until we reach a coma dose. The treatment is given six days a week, Sunday being the day of rest. The injections are given deeply intramuscularly, and the patients must be watched for the development of some sensitiveness against insulin or some allergic reactions. This is one of the reasons why we start with so small a dose. If a reaction occurs, it is often sufficient to change from one make of insulin to another.

About one hour after injection, the appearance of symptoms of HC starts. The patient feels sleepy, begins to perspire, and there is increased salivation. There may be complaints of hunger and thirst. In the next hour these symptoms increase, the consciousness becomes clouded, the patient appears drowsy — he sleeps. There is a group where the picture presented by the patients is different. We find these in a state of excitement, they try to get up, they toss around, they shout and yell. the third hour, the real HC comes It is the goal of every therapist to give the insulin in such an amount that the shock starts in the Therefore, when the third hour. shock starts too early, the amount of insulin has to be reduced. When it starts too late, the amount has to be increased. It is hard to determine what a coma really is. is interesting to note that many scientists use different criteria for a coma. It might be sufficient to state that in shock or coma the patient does not respond to any stimulus and cannot be awakened. During the coma the patient shows twitchings, absence of reflexes, and presence of pyramidal signs. At the same time, the face becomes flushed, the pulse is accelerated, and the pupils are dilated. At the beginning of the fourth hour the pupils do not

react to light, the eyeballs are turned to one side, the pulse accelerates still more, and the patient appears cyanotic. Spastic waves come on, and the pupils later contract. The pulse rate formerly high begins to slow down, and the respiration is forceful. This is reached at the fifth hour. Such a comatose condition should not exceed fifteen minutes during the first treatment, and it should never on repetition last over one hour. The deepest part of the coma should never extend more than twenty minutes

When you hear that in some cases 1,000 units of insulin are given to produce a coma, you will be interested to learn that I have seen a coma after the administration of only 8 units.

What steps are taken to produce coma when it does not commence on daily and correctly increased dosages of insulin? In such cases, we use one of the so-called zigzag methods. This means the rapid dropping and increasing of dosages. By this means a coma is often reached with a dosage which previously was not enough to produce therapeutic effect.

When the coma has lasted long enough, the treatment has to be terminated, and this is done by different means. Sugar solution may be fed by mouth if the patient can swallow, or through a nasal tube. However, the danger in the latter method is that the patient, who is still unconscious or semi-conscious, will not produce the warning signs that the nasal tube lies in the wrong place. The third and most important way of terminating a coma is the use of glucose solution intravenously. Here the complication lies in the fact that the repetition of this injection leads to closing of the veins. For emergency manipulation, one vein at least should be in proper condition so modifications of treatment have often to be adopted.

When you visualize the various hours of a treatment day and the reaction which the patients produce, you will understand that the treatment room has to be equipped with everything that is necessary to count-

eract any complications which may arise.

It is believed that fifty to sixty comas should be applied before insulin treatment has to be discontinued. This number should never exceed one hundred as there is a danger of brain damage. Such brain damage may occur after a so-called protracted or prolonged coma — one in every 1,800 cases — which may last for days. The patient is always in a dangerous condition, which occasionally leads to surprising improvement, but more often causes irreparable brain damage, or may lead to death.

Numerous references in literature deal with the observation on body fluids, with findings on heart actions, pulse rate, electrocardiogram, and so on, but these will not be discussed here. As to the psychiatric observation, I would remind you that even a normal person under insulin shock therapy would act rather oddly. We have to assume that there is a typical reaction which follows the overdosage of insulin. It is very hard to distinguish what due to this intoxication, what is due to hallucinatory processes which flare up during treatment of our patients. Our patients are able to report their own reactions during the first few hours, but there are only a few reports covering the real coma.

It is interesting to watch the awakening from HC. First the reflexes reappear, then the motor functions become normal, patients respond to stimuli, and lastly their speech will be normal. Most patients have their own way of awakening, and do not change it during treatment. Immediately after termination, patients appear relaxed, they ask for food, they start conversation, and they are definitely more in close contact with the real world. After a few hours, they may swing back to their psychotic signs and live again in a dream world. As insulin treatment brings improvement, the hours of well-being begin slowly to lengthen, and the intensity of the psychotic phenomena fades slowly away. The

hallucinations become fainter, the voices are farther away and more indistinct.

The best thing which we can hope for with our treatment is to improve the patient to such an extent that he is nearly or absolutely as he was before the acute disease developed. Our patients often show signs of having been introverted many years before an acute process started. will understand that we do not expect to alter the pre-psychotic personality, but will see the patients just as introverted as they have been before they became acutely ill. Despite all observations made so far, we do not know what really takes place in the brain and what changes cause improvement, but we do know that insulin treatment is the ideal treatment for special forms of schizophrenia, especially the paranoid and catatonic forms. It is definitely the treatment of choice when these forms have not been present longer than one year. Whatever skepticism we may have, each patient who can be treated should have the opportunity. This conclusion is derived from the fact that today we are not in a position to make a clear-cut diagnosis as to which group the patients may belong in.

I have tried to give some outline of the treatment with insulin. I would like to point out now only one phenomenon. Occasionally during the insulin shock treatments we see the occurrence of real epileptic seizures. This brings us to the second form of therapy in which these seizures are just our goal. A few observations regarding the convulsive therapies will indicate their value.

There are two convulsive therapies, one performed by the injection of metrazol. It was von Meduna who, in 1935, reported on his new treatment for the first time. He came to his conclusions under peculiar considerations. It was known that schizophrenics very seldom suffer from epilepsy, and so he thought that one disease might rule out the other. The use of metrazol, a camphor

preparation, has a predecessor. In the year 1785, an Englishman named Oliver reported on the treatment of mania in the *London Medical Journal*. It was the belief that the convulsive therapy would turn out to be a treatment for schizophrenia, as is insulin, but it developed that the use of the convulsive therapies lies mostly in another field.

This drug, sometimes up to 40 cc., is given intravenously. Between three and thirty seconds later, a very brisk convulsion occurs, but the interval between the injection and the convulsion, short as it may be, produces a fear of death on the patient, so much so that he often refuses a repetition of this treatment. This feeling of impending death and sudden annihilation, together with a special type of epileptic seizures which often bring on severe fractures, is responsible for the fact that electric shock therapy is gaining steadily in popularity, whereas the metrazol treatment seems to be on the decline.

In 1937. Cerletti and Bini introduced the electric shock therapy. Small electric sets are used for the application of this treatment. The patient is placed on a flat table which has a hard mattress as the best covering. The spine is bridged over a sand bag. Artificial dentures, hairpins, etc., are removed. It is a good idea not to give the patient any or very little food before the treatment. A paste is then applied to the area over the temples and on these spots a special forceps is applied in order to conduct the current to the patient. Why is just this area chosen for the appliances? The various parts of the brain do not equally admit electric currents. This area has the lowest threshold. After the resistance of the patient is measured, the current is again set in motion, and in a very short time a seizure occurs which is absolutely equal to the real epileptic seizure. As it develops slowly, and, of course, can be adjusted in intensity, the danger of fractures is less than with the metrazol treatment.

It may be interesting to point

out that the threshold is different in each sex, and that the threshold increases in older people and also on repetition of the treatment. Curiously enough, hours and sometimes weeks later electric currents can be found in the brains of patients, currents which definitely were not there before the treatment was set in motion. These currents do not cause any harm and there seems to be no connection between them and the results of the therapy.

The temperature and humidity of the air is of importance in this treatment. On cold and dry days,

the threshold is higher.

The patient, having developed grand mal, comes out of it very quickly. He is confused and may complain of headache and dizziness. The patient, who has responded with petit mal, may become temporarily confused, but in both cases we find amnesia. The patient who has known his doctor for weeks and months will not recognize him at all. Many of our patients complain of impairment of memory which gradually improves.

Fractures may occur with electric shock. One of the most common complications is the dislocation of the jaw. Many doctors stress the danger of fractures so it is wise to protect when we suspect very weak bones, by x-ray of probable areas before treatment is started.

before treatment is started.

Between five and twelve electric treatments are given, from two to three a week, but should a relapse occur there is no reason why this treatment cannot be repeated. The chances on repetition are just as good as before.

Some physicians use a prepara-

tion developed from curare. The use of this old Indian poison blocks the communication between the nerves and muscles. In other words, its use in our therapy is as a breakwater which does not permit the impulses from the brain to reach the muscles, or they may reach the muscles only in a very mild form. The use of this preparation has some disadvantages also, and the majority of therapists do not use curare generally.

One word regarding the fatalities in shock treatment should be added. A survey in all American hospitals reveals the following death rate: 0.06 per cent for electric shock therapy; 0.1 per cent for metrazol:

and 0.6 per cent for insulin.

Generally we use the insulin treatment for schizophrenia and the convulsive treatment to combat depression. When we have to deal with affective disorders the convulsive treatments are the treatments of choice, but it is with real depression and the depression occasioned by the menopause that electric shock therapy is most effective. are reports which speak of from 80 to 100 per cent remissions. Whereas the insulin treatment is most hopeful when the patient has not been ill longer than one year, time does not play a part in the convulsive treatment.

Recent years have given us the armament to combat actively certain psychiatric phenomena. For a long time there was a belief that psychiatry was missing out by not using active therapy. This outline shows a branch of active therapy which is now used, and very successfully, all

over the world.

Advice to Physicians Vintage 1100

A guide book for doctors written about the year 1100 in Salerno, Italy, under the title of *The Physician's Visit*, gave this advice to the doctor: "When called, commend yourself to God and the angel who guided Tobias. Learn as much as you can from the messenger so you may astonish your patient by your knowledge of the case. When you arrive, sit

down, take a drink and speak of the beauty of the country and the house. Next feel the patient's pulse, but remember that it may be affected by your arrival, or by the patient's thinking of the terrible cost of your visit. Tell the patient you will cure him, with God's help, but tell his friends that the case is very serious.

Start Talking!

PRISCILLA CAMPBELL

NURSING MUST TELL ITS OWN STORY

LACK OF INTEREST, respect, and support can be fatal to the life and effectiveness of any public service. The chief reason for lack of interest, understanding, and support of nursing lies in lack of interest and aggressiveness on the part of organized nursing to tell its own story, present facts and figures, and emphasize the responsibility that enjoins upon every nurse from early student experience on through to the top-ranking members of the nursing profession.

The story has its origin in a proud and honorable record of service rendered on behalf of a great and noble public, a story which will bear telling again and again and with pardonable pride. This fact is sometimes referred to at nurses' meetings and perhaps on the occasion of such auspicious public functions as a School of Nursing Commencement. From there on the community gets its information about nursing wherever and however it may — from incomplete reports, half-truths, and sometimes unfounded rumors. Members of the profession seldom are prepared to answer questions about nursing or to speak freely and with confidence on behalf of this essential public service.

Self-expression and the expression of an organization such as nursing takes many forms. It is projected by the smallest details in actions, manners, speech, attitudes, and writings of its members. It is our privilege, our duty, and our responsibility to give a good account of nursing. We live in a society that offers rewards only to those who can interest, impress, and inspire the abilities and effort of others on behalf of the cause in which we ourselves are interested.

LEADERSHIP

The penalty for a job well done is another and even more important task to be undertaken. Leaders in

nursing must take on another important assignment this time. We must organize and direct a carefully planned program of public education designed to inform church organizations, civic bodies, women's organizations, service clubs, students in secondary and special schools, and citizens generally about nursing—how the present system of schools for student nurses is organized and operated; what is contained in the basic educational program for the student nurse; what the nurse education program costs per student; who pays for it and who employs the qualified registered nurse upon completion of her basic training.

Off in the distance I hear a voice protesting — the public does know about nursing! They seem to know when they want nursing service. Certainly they do; but they do not know how this essential health service is provided and maintained. Why do they not know? Because you and I have not taken the time nor put forth the necessary effort to inform them. We have allowed persons uninformed to speak publicly on behalf of nursing. Every nurse must share in this task and we all have endless opportunities to speak of nursing if we will take the time and make the effort to do so. The times in which we are living provide for nurses their greatest opportunity to do just this. Nursing activity is in the news. People are interested and are asking questions and we must be prepared to answer. It's easy to get attention now. We must be prepared with the facts and state them openly, tactfully but frankly. If we do not convince all our listeners on the first attempt, we must accept disappointment gracefully. We must never stop trving.

THE NEW RECRUIT

Our program of public education must commence with the newest re-

cruit to the nursing ranks. It is, therefore, essential that we begin at the beginning with the most junior student immediately she enters the nursing school. Special effort must be made to interest, to stimulate, and to maintain her interest in nursing. may be accomplished by spending more time informing students about why and how schools of nursing are organized and operated, according to the present system; what is contained in the nurse education program; the value of a clearly defined department of nursing within the hospital; and, right here, why and how nursing must tell its own story to the community; why it is essential that we must improve our relations with the public whom we serve: and how the youngest recruit may assist in this achievement. to the student of nursing the kind of experience and education in which she can take pride; compile facts and figures for her; give her some instruction in public speaking; encourage her to talk about nursing to her friends; and to feel that it is her privilege and her duty to speak freely about one of life's finest experiences. Let us once and for all get rid of the ancient idea that has prevailed for so long, and still is evident, that the nurse is a self-sacrificing soul who must be seen only at the bedside of the patient and seldom if ever heard to speak outside a meeting of nurses.

THE QUALIFIED REGISTERED NURSE By their works you shall know them — is a time-tested proverb. Achievements speak the loudest of all of the factors of public relations. The cornerstone of a sound, effective public relations program is the provision of quality service. The assignment to be undertaken is not a task for the few. It is a program in which every qualified registered nurse must share regardless of time or special talents. It begins with the superintendent of the school of nursing and director of nursing services whose job brings her into contact with many and varied people from all walks of life. Her opportunities to

give a good account of nursing by action and by the spoken word are unlimited. The department supervisors and nurse instructors share with their superior in spreading goodwill, understanding, and appreciation. If interests are directed into the proper channels, the general duty nurse forms an important link in the chain and can assist to a marked degree in the influence and benefits of the program that has been planned and put into motion. She must be in complete accord with the policy and principles of the task in hand and must concern herself with quality nursing service.

The private duty nurse enjoys one of the most excellent opportunities to give a good account of nursing in terms of services rendered, and in conversation with her patient, his friends, and neighbors. She too must make quality service her ideal. No nurse makes a greater or more lasting

impression.

The public health nurse through her special department of nursing enjoys a wide range of community contacts as a health teacher and guardian of our most priceless possession. The school nurse, through contact with the children and their parents, can be the ideal nurse in the community. She can, if she will make the effort, inspire in the minds of youth a confidence and respect for nursing that few other nurses have an opportunity to accomplish. The industrial nurse now takes her place alongside the sons and daughters of industry, tending their wounds and offering advice on matters of health and welfare to the employee and his or her dependents. Industry has been quick to recognize the value of the services of this trained worker in keeping the wheels turning. With proper leadership, industry can wield a powerful influence on behalf of nursing.

PUBLIC RELATIONS

Public relations programs are measured in terms of public interest and social value. Do they deserve to succeed because they contribute to public welfare? Do the persons

actively engaged in them have a highly developed sense of public welfare and

public service?

Interest and assistance will be forthcoming only when we as nurses go out after it. The community expects to receive this information, inspiration, and leadership from nurses.

THE TRUSTEE

Now that we have undertaken a campaign of enlightenment for our members and have put at least a part of our plan to the test, we may venture to discuss the much-needed assistance of the trustee. We realize full well that nursing is a community service. We as nurses cannot carry the responsibility for the service without community interest and support. This interest and support can best come through the efforts of volunteers acting in the capacity of trustees serving as the link between the nursing organization and the community which it serves.

Hospital and nursing school trustees. as I know them, are public-spirited men and women with varied interests experience, each possessing public service ideals and a desire to contribute in time and personal effort to the development of a worthy community project. For the particular task before us, the trustee must be chosen with the utmost care and consideration of his personality, ability, personal interest, knowledge of community needs and community welfare. After the selection and appointment of the trustees, be they ever so promising, we cannot heave a sigh of relief and relax. No indeed! Not by any means. Too much of that has already been done and with nearly disastrous results. We must be willing to spend extra time and make special effort to keep our trustees informed about nursing needs. We must not expect these good folk, regardless of their zeal for the cause of nursing, to understand nursing organization, operation, and service. This will come slowly and we must be patient. If we truly want our cause to progress, we will gladly spend the time and effort, and miss no opportunity to discover

just what the trustee's attitude and special abilities are; what his business and social interests are. We will bend every effort to keep our trustees informed and in touch with all sources of information on nursing. It is a special piece of work worthy of special attention by all our members

Charlotte Whitton has once again pointed out, in a timely and well thought out article about women in public life, that it is time for women to learn the facts of political life civic, provincial, and federal. I agree most heartily and would venture to suggest that it is time the nurses of Canada as a national organization were thinking in terms of political leadership and that we now select and prepare one of our members possessing special qualifications for such a post. Oh ves! I know we may be shocked at the idea. We were also shocked to find that the small amount of funds from the government treasury, voted in support of nursing education during recent war years, was one of the first government expenditures to be cut as soon as hostilities ceased. The presence of a nurse at Ottawa probably would not have altered this. However, she would at least have questioned such a move, and would have suggested reasons why this curtailment should not have been made. Enlightening information and advice on behalf of an essential health service could be frequently offered. Opportunities would have to be sought to present facts and figures on nursing needs and nursing costs to the moneyspending bodies. One can readily visualize the presence of the especially well qualified nurse executing a marked influence on behalf of a public service that is little known to governmental bodies. Someone has already said, "How do you think you are going to finance such an undertaking?" Canadian nurses have raised money before — large sums of money for other worthy projects - and they can do it again. We have been reminded that time is running out and that an election is in the offing. We had better face up to the facts

as they exist, consider nursing problems as they are today. Otherwise we shall be standing by watching a public service essential to the life of Canada become a pale shadow of the dignified and honorable public service that organized nursing should perform.

Hospital Penicillin Treatment Centre

SISTER M. DÉCARY

THE ADVANTAGES of penicillin therapy in the treatment of certain diseases are so obvious that physicians are prescribing this antibiotic more and more frequently. In order to obtain good results with penicillin it is absolutely essential that the required dose be given at regular time intervals and for this reason the patient is generally hospitalized.

The patient submitting to the treatment has a right to receive the prescribed amount of penicillin at the time intervals specified by the doctor to ensure a rapid recovery. He also has a right to a painless or

almost painless injection.

The administrator, bearing in mind that the hospital exists primarily for the welfare of the patient, is ready to co-operate with the medical staff by providing whatever is necessary for effective treatment. This method presented no difficulty until penicillin prescriptions became increasingly more numerous, whereupon the established system proved cumbersome and unsatisfactory.

A comparative month by month study of the number of 100,000-unit vials, consumed for injection pur-

poses, appears herewith.

To serve at all hours, day and night, to label and to charge as many as 1,663 vials such as was done in August, 1946, is no small task for the pharmacist, especially during the summer months when vacations are in force and help is limited.

As the demand for penicillin grew, charge and credit slips routinely forwarded from the pharmacy to the business office caused a perceptible increase in the clerical work as well.

The head nurses were obliged to make a tiresome daily check on

	Jun.	Feb.	Mar.	.1 pr.	May	June	July	.1 ug.	Sept.	() _' .	Nov.	Dvc
1945.	236	196	154	218	422	27()	264	317	433	391	7.3.3	91.5
1946	878	1182	1314	1280	961	1038	1267	1663	1304	1875	1410	1550

ONE HOSPITAL'S EXPERIENCE

In the distribution and administration of penicillin in our institution we at first followed the procedure in current use for all other medications: i.e., single vials of 100,000 units were requisitioned from the pharmacist, labeled, dispensed to the department, dissolved by the nurse, and administered as needed. When a given vial had been exhausted, another was procured in the same way.

all the penicillin being used in their respective departments, and to ensure proper refrigeration of the drug. They were also responsible for making certain that the unprecedentedly large number of intramuscular injections were given in correct dosage at the proper time. Because of constantly changing staff and rapid turnover of patients, it can readily be seen how exacting was their responsibility. These are only a few

of the undesirable features of the original system.

EXPERIMENT TRIED

After a few months of study, a plan of centralization was formulated and was put into effect May 30, 1946, in one department only, with bed capacity of 48. In this department, from 90 to as many as 110 injections were prescribed in one 24-hour period. A routine was set up, one nurse being delegated to handle all vials and syringes and to keep a record of injections in a special book. The plan worked well. Doctors, nurses and, especially, patients were relieved of The diffimuch needless anxiety. culty of providing a supply of syringes was greatly reduced by using one labeled syringe per patient for each 24-hour period, with sterile needles being supplied for each injection. We modified and improved this system from day to day until finally it was considered practical enough to warrant its application to all patients undergoing treatment in the entire hospital.

ORGANIZATION

On October 7, 1946, the Penicillin Treatment Centre began to function as an organized unit. From that date, responsibility for procuring and administering penicillin throughout the hospital was supervised by one graduate nurse. The plan of organization is as follows:

- 1. The centre is located in the central supply room where a refrigerator has been installed for the storage of penicillin stock, syringes, trays, etc.
- 2. Vials containing 500,000 Oxford units of penicillin each are used exclusively.
- 3. Two sterile trays are set up for day and night use alternately, each containing the following supplies: (a) 5 cc. and 10 cc. syringes; (b) towels; (c) cotton balls; (d) No. 22 intramuscular needles in bulk (on compresses in a pleated towel); (e) No. 19 needles for dissolving penicillin.
- Square-ruled record note-books are used as follows: (a) One in each department in which are listed the names and room

numbers of all patients getting penicillin, with the dose and time-schedule copied daily from the chart by the head nurse; (b) one in the Penicillin Centre summarizing the information recorded in the department books.

- 5. The graduate nurse in charge of the central supply room instructs a senior student in the preparation of supplies and administration of injections.
- 6. The centralization plan operates on the principle that, with the approval of the medical staff, "semi-sterile" technique may be used in penicillin therapy.

PRESENT PROCEDURE AND ITS AD-VANTAGES

Economy: A 500,000-unit vial of concentrated solution is prepared by dissolving the vial in 10 cc. of solvent which yields 50,000 Oxford units of penicillin per cc. of solution; $12\frac{1}{2}$ cc. of solvent yields 40,000 Oxford units per cc. of solution. Varying the amount of solvent in this way one can produce any strength of solution desired. A 12-hour dosage of penicillin for each patient can be drawn into a 5 cc. or 10 cc. syringe, thus permitting the injection of a fractional part of this supply for each individual dose, and the retention of the remainder for subsequent doses during that 12-hour period. Needles, of course, are changed after each injection. 12-hour night supply can be prepared in the same way.

This concentrated solution provides an injection of lesser volume and thus causes a minimum of discomfort to the patient and takes less time to prepare. One 500,000-unit vial lasts five times as long as the 100,000-unit size. For instance, by investing in the 500,000-unit size, the 1,663 100,000-unit vials consumed in August, 1946, could have been reduced to 332 3/5 vials.

Syringes: The present system uses exactly one-eighth the number of syringes as compared with the former method. To illustrate—if 20 patients are receiving penicillin injections every 3 hours, a total of 8 doses per patient every 24 hours, 160 doses must be given. In that time, accord-

ing to the former system in which one syringe was required for each dose, 160 syringes would have been needed to give 160 doses. According to the present system, employing one syringe per patient per day, 20 syringes are needed to give the same 160 doses. Calculated for one week, we arrive at the following:

160 syringes per day x 7 equals 1,120 syringes per week; 20 syringes per day x 7 equals 140 syringes per week.

Using one-eighth the number of syringes has two distinct advantages: (1) Much less material to clean, sterilize, and store; (2) much less breakage. The syringes are put up in bulk to be sterilized in the Penicillin Set. No individual wrappers or containers are needed.

Needles: To dissolve and draw the penicillin, No. 19 needles are used; the No. 22 intramuscular needles are thereby not abused by insertion into rubber-stoppered vials. The needles are used by the same nurse who is trained to care for the equipment for which she is responsible.

Analgesia: With the use of No. 22 needles for injection purposes only, we have observed a marked reduction in requests for procaine or metycaine. Formerly 30 to 40 per cent of the patients on injection therapy received some form of local anesthetic with each dose of penicillin. At present, only .2 per cent of patients receive it.

Recommendations: Between doses, the syringes containing penicillin are stored on trays marked for each department in the refrigerator in the Penicillin Centre at 15°C. or below. Each tray is covered with a sterile towel. When not in use the syringe barrel is slightly elevated at the hub to prevent escape of the medication by gravity. If this last detail is not observed it is surprising how much penicillin can be wasted.

When making rounds to give injections the identical route should be followed invariably. This is important because of the time element involved in penicillin treatment.

The department penicillin books

	9	a. g.	1	N.P.
	4			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	2	Z. G.		
	2			Z.
	12	z.		N.P. N.P.
	10		disc.	a. Z
dule	6	N. G.		
Time Schedule	00			Z.
Ti	9	D.D.	D.D.	D.D. D.D. N.P.
	7			D.D.
	~	D.D.		
	2		D.D.	starte d D.R. D.D. D.D.
	12	D.D.		starte D.D.
	10		D.D.	
	6	D.D.		
	00			
	Dose in cc.	- 5	-	72
	Dose in Units	20,000 q.3.h.	50,000 q.4.h.	25,000 q.2.b.
	Patient	John Doe 20,000 q.3.h.	324-2 Mary Jones, 50,000 q.4.h.	425-1 Anna Brown 25,000 q.2.h.
	Room	1.86	324-2	125-1

\$x.xx Charge for medication (Does not vary)	Units per dose	Number of injections given	Charge per injection	Total charge to patient for treatment (varies)
800,000 units	100,000	8	\$0.10	\$x.xx plus .80 -
800,000 units	50,000	16	0.10	x.xx plus 1.60
800,000 units	25,000	32	0.10	x.xx plus 3.20
800,000 units	20,000	40	0.10	x.xx plus 4.00

should be kept in a uniform place in each department—e.g., the head nurse's desk. The nurse administering penicillin must strictly adhere to the practice of initialling the square under the time of dosage immediately after making rounds in each department. In this way the head nurse can see at a glance whether or not a patient has received the prescribed dose. The penicillin record book in the central supply room is also initialled for each dose but only after a complete series of doses has been given.

For obvious reasons, telephone messages from the head nurse of any department are accepted for "stat," "discontinued," or "changed" orders. But whether telephoned or not, all orders and changes must appear in the department penicillin book as soon as

received.

Time schedule: The following time schedules were adopted by the Penicillin Treatment Centre:

Doses on a 2-hourly basis are given at 8:00, 10:00, 12:00, 2:00, 4:00, 6:00; doses on a 3-hourly basis are given at 9:00, 12:00, 3:00, 6:00; doses on a 4-hourly basis are given at 10:00, 2:00, 6:00.

Day doses are recorded and initialled in blue pencil. Night doses are recorded and initialled in red pencil.

FINANCIAL ASPECTS

Since the organization of the Penicillin Treatment Centre, there has been a marked reduction in the number of vials purchased by the pharmacist, resulting in one-fifth the amount of storage required. Instead of storing a 15-day supply of 24,945 vials the amount is now reduced to 4,989 vials.

The labeling and charging of this vast number of vials have been eliminated. The central supply room provides for a 24-hour supply, serves each dose from stock solution, charges per dose, and forwards the charge slips to the business office daily at 3:00 p.m. According to the above method, uniformity of charges is maintained for all patients.

A table of charges is used for billing patients and a nominal fee is

charged for each injection.

Conclusion

The success of the Penicillin Treatment Centre indicates the practicability as well as economy of controlling the distribution and administration not only of penicillin but also of streptomycin and other medications given in divided intramuscular injections.

Credits

More than \$8,000,000 in re-establishment credits was disbursed on behalf of ex-service men and women during the month of May, 1947, by D.V.A.'s Re-establishment Credit Division. The overall total of credits paid

up to the end of May was \$136,179,256, while the month's payments amounted to \$8,151,266. Fifty-five per cent of all credit payments have been approved for the purchase of furniture and household equipment.

Training Nursing Assistants

DOROTHY G. RIDDELL

X June, 1946, an inquiry was made by the Minister of Health into the problem of shortage of nursing personnel in hospitals in Ontario. Information was obtained from all hospitals with the exception of federal and private institutions. The widest possible expression of opinion was sought regarding methods which ought to be employed in solving the difficulty of securing adequate staff, by the question: "What suggestion can you offer toward a solution of the general problem?" The chief suggestion obtained was for the establishment of training schools and the provision for licensing of nursing assistants.*

The Minister, in July, called a meeting which was attended by representatives of the Registered Nurses Association of Ontario, the Ontario Medical Association, the Ontario Hospital Association, and the Department of Health. This committee approved the establishment of a ninemonth course for the purpose of training nursing assistants under the provincial government. It recommended that certain hospitals might also conduct courses, provided they established on a satisfactory basis. The committee suggested that an Advisory Committee of thirteen members be formed, upon the invitation of the Minister of Health.

The Department of Education had been interested, prior to this, in the Practical Nursing Course in the Canadian Vocational Training program. They expressed their interest in the Nursing Assistant Course too. As a result money was made available for the establishment and conduct of courses under the joint direction of the Departments of Health and Education, and the first courses began in September.

The first publicity was released to the press in August, 1946. then there have been periodic announcements in all papers about incoming All hospitals in Ontario were asked to assist in obtaining suitable applicants. Information about the Nursing Assistant Course has been given to employment agencies, various organizations, vocational guidance counsellors, and on request. In December, 1946, the Advisory Committee recommended that the educational admission requirement be changed from Grade X to Grade VIII. The approval of the original committee was sought. It was deemed advisable to make this change since the enrolment without it was not sufficient to warrant the expense involved.

A careful selection of trainees is made by the Nurse Registration Branch. Wherever possible a personal interview is given. The admission requirements are:

Grade VIII education; medical certificate of good health; age limits of 18 to 40 years; letters of reference from a minister or priest, a citizen, a former school teacher, and a relative; an interest in nursing.

Applicants who are residents of Ontario are given a monthly allowance of sixty dollars and transportation is paid from the applicant's home to the Training Centres. A complete



Stud In Pa

The Anatomy Lesson

NOVEMBER, 1947

^{* &}quot;Statistical Survey in Nursing Personnel in Ontario, June 1946"— Medical Statistics Branch, Department of Health.

medical examination, including immunization, is given on admission to the course. Individual arrangements are made with each hospital for provision of medical care in case of illness. A terminal medical examina-

tion is given.

Uniforms are provided: The design has been carefully selected and the uniform is made to measure. It consists of an apple green one-piece dress, over which is worn a white apron designed on princess lines. Brown shoes and stockings are worn. At the end of the six-month course the trainee receives a cap. It is white with a green piping. After graduation and as long as she is employed in this type of work it is hoped that the nursing assistant will continue to wear this distinctive uniform.

The Departments of Education and Health shared in the organization of the course. The Department of Education has provided and equipped the three training centres under the Training and Re-establishment Institutes. They have made available to the training centres, secretarial and accounting staff and have provided additional teaching staff, such as part-time dietitians.

The Department of Health, Nurse Registration Branch, has appointed Miss N. Margaret Dulmage as in-



N. Featherstone Cowley
MARGARET DULMAGE

spector and supervisor of the Nursing Assistant Courses. Her responsibilities include the evaluation of hospitals seeking approval as training centres, supervision of the teaching staff, and the co-ordination of the training centres and selected hospitals. She will consider the objectives of the courses and will endeavor to set standards for this type

of worker in hospitals.

The Training Centres are located in Hamilton, Kingston, and Toronto. They are attractively equipped. Each centre has a room for practical instruction in nursing, facilities for teaching cookery, classrooms, library, instructors' office, rest and recreation rooms. The Hamilton Centre is at the Training and Re-establishment Institute, Kenilworth Avenue North. The building was formerly an officers' mess. The Kingston Centre is located on the second storey of a fine stone building which was used for a business college. The address is 321 Oueen Street. The Toronto Centre is at the Training and Re-establishment Institute Annex, 206 Huron Street. The instructors welcome visitors to their Centres for they are aware that their units are distinctive and well worth seeing.

The teaching staff at each Centre consists of a chief instructor, assistant instructor, and supervisors for the hospitals. The staff at present is:

Hamilton Centre: 2 instructors, 2 supervisors.

Kingston Centre: 2 instructors, 1 supervisor.

Toronto Centre: 2 instructors, 3 supervisors.

Members of the staff are experienced registered nurses. Four instructors have had a year's post-graduate course in supervision and teaching at a university. Five have had experience in the Armed Services. One has a university degree in Arts. All are keenly interested and aware of their responsibilities.

The syllabus, which has been prepared by the Registered Nurses Association of Ontario and which has been sent out to all hospitals in Ontario as a guide in training sub-



Student Veterans Photo, T.R.I.T.

Learning to take T.P.R.

sidiary workers, is the basis on which the course is planned. During the first three months, the trainees receive lectures in nursing and in the structure and function of the human body. There is also instruction in nutrition, personal hygiene, ethics, and housekeeping. Much is required of the teaching staff in the way of individual help, drill, and use of visuals aids. The trainees' experience is broadened by planned trips to a dairy, library, day nursery, and visits to special hospitals.

The program for clinical experience consists of three months in a hospital for the chronically ill and three months in a general or children's hospital. Arrangements are now being made at the Orillia Hospital for Mentally Defective Children for trainees to have some experience in the pediatric wards of the hospital. The hospitals are carefully chosen and arrangements are made on an individual basis. The nursing assistant supervisor in the hospital is responsible for the supervision of the work of the trainees, ward talks, and a few records. She is responsible to the head nurse for the nursing care of the patients under

her supervision. In the care of the chronically ill there is a real adjustment for the young trainee who has never been in a hospital before.

The Training Centres are open five days a week from 8:30 to 4:30 p.m. Trainees in the hospital are on duty eight hours a day, six days a week. They spend about one week on afternoon and night shift each, in order to acquaint themselves with the twenty-

four hour period of duty.

Departmental examinations are set for nursing assistants. A policyforming committee has been made up of instructors of approved schools of nursing in Ontario, and representatives from the Departments of Education and Health. Examinations are set and marked by a board of examiners selected from the nursing assistant teaching staff. The present plan for the qualifying examination consists of one paper, objective type, covering the course of studies. The practical mark is based on the reports of the instructors and supervisors during the nine months' training, and represents 60 per cent of the passing grade. The supervisor, Nurse Registration Branch,



Stud. Vets. Photo Bathing a Baby

may request a practical demonstration in cases where she considers it advisable.

The supervisor interviews each applicant who makes a personal application, and during the course talks to trainees who have problems. In the last month of training each young woman is interviewed again to discuss employment opportunities. Nursing assistants are advised to work under supervision in a hospital or organization in their own community.

On successful completion of the course the graduate is given a certificate and is known as a Certified Nursing Assistant, as provided for by the Nurses' Act 1947.

Letters have been sent to all superintendents of hospitals as to the numbers of trainees available for employment with an outline of the instruction given. Suggestions have been made about salaries. It is pointed out again that the nursing assist-

ant is not a substitute for the graduate nurse and that the function of the nursing assistant is to assist in the nursing care of patients. Many hospitals are welcoming the subsidiary worker on their staff.

The Registered Nurses Association recently requested all superintendents of nurses to recruit applicants locally, to encourage them to take the course, and to offer employment on the successful completion of it. Classes begin each January, April, and September. In the September, 1947, class more than one hundred young women entered training to become nursing assistants.

Eleven months after the inception of the course, under the government plan, figures are as follows:

Enrolled — 235; discontinued — 59; graduated — 52; still in school — 124.

Of the 59 trainees who have discontinued the course, 17 left for health reasons, 14 did not meet the academic standards of the school, 28 left for other reasons, such as marriage, family responsibilities, etc. The number enrolled to date represent 59 communities in Ontario.

Two hospital centres have been approved for the training of nursing assistants. They are located at Picton and Hamilton Sanatorium. Graduates of these courses are eligible to write Departmental examinations and may become certified.

The co-operation of all participating in the course has been an important factor in the progress made to date. The success of the Nursing Assistant Training Course can only be measured by the quality of nursing care given to the public, and to the extent that the numbers who graduate will help meet the demand for nursing personnel.

Health cannot be given to the community by laws, motion pictures, offering advice, or fining those who fail to report disease. The patient, the community, can be as healthy as it chooses or as sick as it is willing to stand for. Only when the community fully understands the reasons for these things will it take an active interest in public health work.

—HAVEN EMERSON, M.D.

German medicine, once among the finest in the world, has fallen to an almost unbelievably low estate. The load of patients is greater than ever before. Many of the hospitals and laboratories are in ruins. Some of the foremost physicians and medical scientists, closely associated with the Nazi regime, still are in concentration camps.

News Notes No. 63

Trends in Nursing

ELEANOR MACINTOSH, B.Sc.

THE NEWSPAPER headlines describing social conditions prevailing today are most disturbing. If utter confusion of thought has dominated the world at any time since the Tower of Babel, it is now. At this crucial time, we of the nursing profession have a serious and worthwhile part to play in trying to turn this To accomplish chaos into order. this we must first evaluate what has been accomplished in nursing and our own professional strengths and weaknesses. Then we must analyze the present nursing trends to see where they will lead if we follow, to determine which should be kept and made stronger, and which should be changed or eliminated.

A span of about seventy years has elapsed since the first schools of nursing were established on this During this time our continent. nursing history has passed rather rapidly from the early "pioneering" years and the "boom" days to the age of "stock-taking" and attempted reform; and recently from the emergency vears of World War II to the present period. We are at the "eve of the unknown" in our profession — a time for instituting a broad educational program which will adequately serve professional, community, and individual needs. Before defining such a program it is essential that we question our philosophy of education. According to the Supplement to the Proposed Curriculum for Schools of Nursing in Canada, "a philosophy of education implies a point of view or attitude towards life, and a belief in what education can contribute to the fulfilment of its highest purpose." What is our characteristic attitude toward education and its problems? Is our dominant attitude conservative opposed to change, steeped in tradition and skeptical of new ideas, or is it liberal — inclined towards experimentation and reasonably hospitable to new ideas? To be dynamic. our educational plan must be built on a philosophy which is capable of change and expansion, vision and foresight.

THE AIMS OF NURSING

The traditional aims of nursing education have been "unquestioning obedience, self-sacrifice, practical utility and technical efficiency." Both science and society are making revolutionary changes today. If we are to prepare nurses to cope with these changes, we must modify our traditional aims so that our discipline will stimulate rather than stultify initiative and self-direction; our self-sacrifice must provide for personal as well as professional growth; and our technical efficiency must be that of a "thinking" person, not an automaton.

The essentials today are knowledge of such activities as will help patients to regain and maintain health; abilities to solve nursing problems and to evaluate results; a comprehension of the "why" as well as the "how" of hospital techniques; and the satisfactory application of health knowledge and nursing service for individuals of all ages in sickness and in health, regardless of race, creed, or economic status. The attainment of these aims in the "World of Tomorrow" can be effected only by stressing the need of adjustment.

What a person "is" is as important as what a person "does." Therefore, nurse educators must aim at developing well-adjusted women who will be intelligent citizens as well as skilful technicians, and who will be happy in personal as well as professional life. We must no longer subordinate the "human" element of our teaching to physical and technical efficiency.

From young and old — from rightwingers and left-wingers — questions pelt with great force about the aims of modern nursing education. Some, timid and skeptical, ask, "Are not these modern ideals too high to be attained?" Some who sense a challenge ask, "How may we fulfil these aims?" Others clinging to tradition say, "Is not self-sacrifice an indispensable requisite of a good nurse?" And then comes the spectre question, "Why is the graduate of today so inferior to the graduate of yesterday?"

Let us challenge this last question with another! What standards are being used to compare and measure the nurse of 1947 with the graduate of 1937? If the former is inferior, is it the fault of the individual nurse, of society, or of the presentday educational system? Is it the fault of the nurse-leaders who are doing the educating? Have there not always been the "good" nurses and the "poor" nurses? Are there not nurses who graduated yesterday nurses who consider themselves in "good standing" -- who exhibit some of the same failings which we criticize in the young nurses of today?

It is not difficult to list these failings for they run the whole gamut of human frailties as they appear in our professional nurses: lack of attention to the professional requirements of uniform, on duty or on the street; thoughtlessness in conversation before students concerning hospital administration; unethical relationships with students; unprofessional shortcuts in nursing procedures; non-support of nursing organizations by lack of attendance at meetings or failure to subscribe to official magazines; leaving the reading of professional literature to a "more convenient time."

Difficulties in personal adjustments loom up spectacularly sacrificing leisure activities and friendships to overapplication to work; intolerance for human weaknesses; racial and class prejudices; and gross failures in the practice of physical and mental health It is so easy to do desteaching. tructive thinking, and very difficult to do creative thinking; so easy to conceal our ideas in the guise of chronic complaints, muttered weakly behind closed doors; very difficult to place carefully thought-out suggestions before the proper authorities. It is easy to listen to rumor and gossip, but very difficult to follow rumor to its source and know the truth of the story. Until we oldsters in the profession can truthfully say that we are free from these weaknesses, it is neither safe nor expedient to assert the superiority or the inferiority of either professional age level or of either system of training — traditional or modern. We who offer ourselves for positions as nurse educators make ourselves subject to all professional ethics and adjustments—we must teach by example as well as by precept. So long as we flagrantly disregard any requirement — even the least of these presented to the students as being essential — we are neither being honest nor conscientious in our endeavor to make modern nursing education successful.

PREPARING LEADERS

The trend toward preparing better leaders for the students of today is important. Provision for full-time study or part-time work at universities has been made. If the savings of a graduate do not permit this expenditure, financial aid is available. Needs for well-trained administrators, instructors, supervisors, and head nurses are increasing steadily. The value of qualified leaders — qualified in personality as well as in technical perfection — is becoming fully recognized. Environmental factors, such as poor health and fatigue, enter into the picture we often see of our capped students - discontent, discouragement, boredom, even open resentment.

Too often, however, students feel inward rebellion against leaders. Personalities are pitted against personalities with resulting feelings and attitudes disguised by disinterest and resentment. Students must have confidence and respect for the judgment and integrity of those who are evaluating their work and guiding them. With an adviser who is overdictatorial and over-critical — more like a foreman than a teacher — or with a leader who is lackadaisical and indifferent, or intolerant of human weaknesses, nursing pays the

penalty in loss of motivation. Leaders in general education today are attempting to teach adolescents to be self-reliant, to develop sound philosophies of life, and to have an adult point of view as they face their chosen career. Have we subordinated this type of teaching to a militaristic way of training those who come under our influence? Are we reaping bitterness and conflict because of this? We must find a middle road for leaders of nursing. Perhaps the sign-board leading to this middle road will be in the preparation of better adjusted individuals who will be our nurse-educators of the future.

CURRICULUM PLANNING

In planning our curriculum today, our yardstick for accomplishment is maintenance of health, whereas less than half a century ago it was the decrease of mortality. It is a rare artist who creates without appreciation, knowledge, and technique of practice. So it is the rare nurse who comprehends her responsibilities as a nurse, a woman and a citizen without opportunities as a student to broaden her philosophical concepts, increase her social knowledge, and practice techniques in the light of modern science. A knowledge of the preventive aspects of disease and the social aspects of life are equally important. Our curriculum must provide for mental hygiene so that nearly one-half the ailments which invalid the human race may be prevented. How varied a nurse's knowledge must be today is easily recognized when we see the remarkable potencies of the new chemotherapy, penicillin, streptomycin, of such biological products as Gamma globulin, and of serums against the degenerative diseases.

With the progress of public health in eliminating the communicable disease menace, a new set of problems arise — those involving the average age level of the population. Hence, a knowledge of the diseases relating to later years becomes most important. In the world of the future, the child will be the vital asset:

so we must integrate into our curriculum planning for the intelligent cultivation of this child of tomorrow. This means a study of the normal child as well as the abnormal child. Since the nurse's responsibility is shifting so rapidly to public health service — hospital service was the sole goal for years — public health in all its aspects must be part of our standard curriculum. A knowledge of community life, of family life, and all the social relationships involved becomes vitally important. With the increase in scientific knowledge, and with the complexity of techniques advancing to correspond with the strides of modern medicine, the length of our course in nursing education remains the same as when nursing was less complicated. We sacrifice our students to servicing the hospitals instead of giving them time to learn yet we call ourselves educators.

Frequently our hospitals and schools are inadequately staffed with qualified personnel. Should there be a sufficient number of specialists, they are often delegated to such tasks as conducting post-graduate or refresher The training of our students courses. in such instances becomes secondary. Students are permitted to repeat simple procedures thousands of times thus allowing the monotony of routine to dampen enthusiasm and to lessen thoughtful action. This in turn results in cynical attitudes and the tendency to follow routine without active intelligence.

Students enter schools of nursing because they wish to *learn* how to serve, yet these novices are disillusioned at the very start because they see their value in service placed before their learning. We have all seen it happen — students foregoing attendance at ward teaching programs because of busy ward routines; students rushing to class late or, if on time, coming with the worries of unfinished ward assignments on their minds.

The modern trend is to staff with a sufficient number of general staff nurses so that the requirements for service by students are materially lessened; to decrease the hours on night duty and provide for a more balanced day of learning and "living." There is also a move toward providing a greater number of clinical instructors; of having classroom instructors specialists rather than one who has a smattering in nine or ten subjects and is an authority on none. The clerical staff will, moreover, be increased to take over the "book work" with which the present-day head nurse and administrator is overburdened.

PRE-NURSING TESTS

Elevating the standards of curriculum requirements and passing levels are constantly being discussed. We often expect a superhuman professional nurse to be produced, but frequently we are not considering the ability of the specific person considered. Do we know the specific abilities under our present testing systems? Can we rely on the recommendations we are now receiving concerning our applicants? Do the people who are doing the recommending really know what nursing education is, and the abilities it requires? Perhaps many heart-breaks on the part of educators, schools, hospitals, and the unfortunate individuals themselves could be avoided if there were a system which classified students in the beginning, and trained them for their specific category rather than give the same training to all. Would this not put an end to the neglect of the bright student by the instructor who is duty-bound to try to pull the less capable student up to a passing grade? No school wishes to be represented by poor nurses; vet, how many mediocre professional nurses are graduated — so mediocre that even the home school avoids employing them. These people go out not only as typical members of a particular school but as typical representatives of our profession.

Pre-nursing tests administered and read by experts are becoming more popular. These tests serve as valuable tools in the selection of students as well as a basis for guidance after enrolment. Through proper guidance a student may be helped to make a more

expeditious and favourable adjustment to nursing. Through careful screening and selection, by early and effective guidance, good professional material may be discovered and proper cultivation administered. Such guidance, as is given in a pre-testing service, saves the applicant, who is low in ability and incapable of meeting requirements, disappointment, disillusionment, bitterness, time and money; the interests of society are safeguarded against inefficient practitioners; and the nurse-educators and schools are saved the expense and unfruitful — even wasteful — use of time and resources. It is important to discriminate adequately between those who show promise and those who do not.

Some definite conclusions have been reached by those who are making testing their life work. One such conclusion is that any grading system, allowing for a more or less decisive and unreasoned grading by an individual with the results expressed in a fixed per cent, without taking into consideration the distribution of the scores, is unsatisfactory and unreliable. The better systems are those which determine the placement of the score by its relation to the average ability of the group involved, and the degree of variability of the individual from the average. does away with group results in which there are no grades above D, or no grades below B. Test results often depend as much upon the teacher as upon the students; faulty instruction must be considered on a level with student ability. Each institution prides itself on the best selection of the finest applicants available; therefore, if we have the best ability that is available for our profession, it behooves us to wonder if our present grading systems are fair or if our own failures as teachers are being considered when our student groups fail to achieve a good distribution of grades.

IMPORTANCE OF HEALTH
We who are guiding students
realize that good health is not a

fixed characteristic - it must be improved. Sunshine and physical activities are imperative. Classes, long hours of study, and ward service keep the student within doors during the daylight hours. This lowers both mental and physical resistance. What is the result? A restless, mentally depressed, physically weakened individual. The accepted cure or prevention is a social program that offers activities during all the hours of the day. This will often change a student from a liability to an asset. The schools of the future will employ social directors who will plan such activities as will be refreshing, mentally and physically, for each student, with these activities made available to resident graduates as well as to students. This planned program may prevent the psychological slump that is epidemic among students in nursing. Opportunities for hobbies, with instruction; organization clubs, space for romping, with shouting; archery, tennis, horseback riding, all within the school — to these our students of the future may look forward.

A CHANGING WORLD

In the twentieth century there have been two wars involving the greater portion of mankind. Out of their turmoil there has developed a cognizance of a constantly changing world, threatening a revolution of our entire social structure. Nurses are concerned with all sides of the question. It is with this in mind that modern nursing education seeks to stimulate health-thinking in the minds of the general population. Already the size of this "thinking group" of the general public has increased beyond the imagination of our forefathers. This accelerated interest is due to mass educational movements, scientific advancements, improved means of communication and transportation, and the hope of better living. These higher standards of living for all are based on democratic ideals. Emphasis is being placed on better housing, slum clearance, better nutrition for all; health regulations which will provide prepayment plans for all health emergencies; building of community institutions for the aged, the chronically ill, and the convalescents; and the organization of community health councils that will plan a family health program, recognizing what each profession can offer on a co-operative basis.

Nurses must be prepared, as citizens, to participate in such programs for this concept of co-ordinating community agencies and resources is permeating the thinking of various parts of the country at this time. Regardless of whether we live in a nursing institution or out in the community. we are still a part of the community and we are citizens. Our relationship with the public is especially important. . It is surprising how many people are still so uninformed about one of the country's most vital professions. It is for us to see that all these people are equipped with the knowledge and understanding of our profession. The trend is toward local professional organizations launching campaigns to overcome the prevalent negative attitude apathy about nursing. Individual nurses themselves must become more active in the community.

THE HUMAN ELEMENT

The question of the necessity for absolute, complete personal sacrifice is a vital one today. It is keeping many desirable applicants from the nursing profession. The nursing profession cannot continue to exist if the idea of sacrificing all personal interests to professional duty persists. Our mental hygienists and our psychiatrists say that fewer beds would be occupied in institutions for the mentally ill if it were not for fanaticisms of one kind or another No other profession expects such a type of self-sacrifice. We are a teaching profession — teaching preventive medicine. Can we teach successfully if we are not living examples of the theories presented? Unreasoned enthusiasm and uncontrolled zest for perfection and self-sacrifice break

physical and mental health and warp personalities. This unharnessed fervor starves those who would like to contribute creative thinking but are forced to be onlookers by the overzealous.

Normal youth today wishes to live a well-rounded and a complete Nurses are normal, not abnormal, in desiring a balanced life, professional interests and work, time religious growth, community and citizenship responsibilities, and personal relationships. The question which must be answered is: shall we permit interested, desirable young women, with ability to train and serve as nurses, to be lost to our profession — to go to other professions — when our own needs them so vitally? Shall we, who are already in the profession transfer to other professions because we cannot agree with the "total self-sacrifice" requirements of many administrators? We have not lost the desire to serve, nor the willingness to attain sufficient education to carry on advancements in nursing.

Out of all these problems has come the need for adequate personnel administration and counselling, the object of which is to hold efficient nurses and administrators and to secure such students as will become desirable representatives of our profession. Our nursing service must be effectively conducted and constantly improved. Sound personnel administration is good business policy; it reaps great benefits in the end.

Personnel practices are becoming so essential that college courses are being devoted to this subject, and nurses are specializing in the field of guidance or counselling of both graduates and students. All who are potential teachers should realize their responsibility to consider the student as a whole. "The student is as important as what the student does." The personnel point of view puts emphasis upon this factor, adapting college methods to the solution of problems faced. This opens a new field for nurses of the future the trained counsellor.

Only a few of the trends of modern nursing education have been discussed here. Space does not permit discussion of the role of the university schools of nursing in our present-day planning. The accreditation of schools of nursing is another forward-looking step which is in the offing. There is a quotation from long ago: "If a man have a garden in which there are poisonous serpents and beautiful flowers, he must first deal with the serpents before he can enjoy the flowers." Let us eradicate the poisonous serpents in our professional garden by facing and accepting the fact that improvement can and must be made, rather than being of the group who curse the darkness. Let us take appropriate action and, if our end results sometimes are unsuccessful, let us remember the adage: "Man's tower of strength is in his mistakes — the man who really succeeds in life is the man who is willing to begin again."

Hepatitis Research

A laboratory for the study of infectious hepatitis has been set up at the University of Heidelberg. The causative organism and method of transmission of hepatitis, which first attracted wide attention during the war, thus far have defied detection. It is a malady characterized by fever, nausea, and abdominal disturbances—usually accompanied by the yellow color associated with jaundice.

Thus far it has been established that it is due to a filterable virus. The virus itself has not been isolated. It has not been possible to

find any experimental animal which is subject to the malady. The virus is known to be extremely infective, but there is no agreement as to how the disease is spread or as to its incubation period. There is some evidence that the virus is spread from person to person in water. There also is some reason to believe that the disease is much more common than generally supposed and that it often appears, like the better known poliomyelitis, in a subclinical form which is not recognized by the victim.

—News Notes No. 63

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Public Health Nurse and Mental Hygiene

CHARLES H. GUNDRY, M.D.

THE PUBLIC HEALTH nurses have become a great influence for general education about matters affecting health by the persistent application of a simple principle. People are interested in learning about matters that touch their own lives closely and may understand in a general way that vaccination and the use of cod liver oil are considered to be valuable for the protection of health, and still neglect to apply the knowledge because of a sort of inertia and a comfortable ostrich-like feeling that smallpox and rickets are remote troubles that might bother people in less favored places but couldn't strike their own families. The public health nurse does two things to overcome this sort of isolationism. In the first place she appeals to children and their parents on the basis of friendship. She knows them personally and brings information about good health practices to them in informal personal chats which can be much more persuasive than impersonal printed material or mass instruction by radio. In the second place she shows them how measures designed to protect and promote good health apply to them personally.

The campaign to popularize the use of cod liver oil has been pretty well won. Now there is a very lively interest in mental illnesses and per-

sonality difficulties. Magazines and movies devote a good deal of attention to these topics. People are more open to information about psychiatric subjects than they ever Until very recently were before. the general attitudes towards any "mental trouble" were to consider it as a family skeleton to be well hidden or to camouflage it as a "decline" or "breakdown" or sometimes to parade it as a mark of distinction genteelly called "nervousness." Certainly there is a growing tendency to be more open-minded and realistic about emotional and mental problems.

Psychiatric disabilities of all sorts are very prevalent and they bring grievous personal suffering and great financial expense. They constitute one of the great public health problems. The public health nurses are trying to do their share towards the prevention of these illnesses by applying the same methods of individual friendly teaching that seem to have been effective in other fields.

There are good grounds for thinking that this approach should be effective in helping to prevent psychiatric disorders. Severe mental diseases, definite neuroses, and disabling disorders of personality do not develop suddenly as a rule, though the obvious onset of an episode may

861

NOVEMBER, 1947

be acute. The onset of an acute phase of a psychiatric illness may be related to some stress or difficulty affecting a person just at the time of his illness. However, as well as the seed there is always the soil. It is not possible to make life free from difficulties and emotional conflicts but it is possible to make the soil, which is individual personality and group morale, very inhospitable to the seeds of mental illness. preparation of the soil for that purpose must begin in infancy. It requires that babies and infants be given a sense of emotional security, that they be loved wisely and treated as if they were important individuals in a family democracy where each member is important. It does not require that they be allowed to become domestic tyrants at two years of age. It requires that the divine individuality of each child be encouraged to develop. Children differ in many ways — physically, intellectually, and temperamentally. It is the ways in which they differ that make children most appealing and adults most creative. Obviously, individualism run amuck would make social living altogether too exciting and would be wasteful, but there is much evidence that restraints and inhibitions, too arbitrarily imposed, can have just as dangerous consequences. For instance, aggressiveness in children must be controlled and the control of crude infantile aggressive behavior has always been one of the main aims of traditional methods of child train-That aim is not open to critiing. cism, but often the methods and results are. If a child is brought up so that he finds outlets for his aggressiveness, first in opportunities for a moderate amount of self-expression in competition with other children and, later, in striving for the common good, and for competence in his own work, then he will probably have satisfactory stability and be easy to get along with. If the attempt is made to repress all expression of aggressiveness on the other hand the

result is likely to be development of one of two extremes of personality - the "milk-toast" type with neurotic symptoms or the aggressive impulsive person always throwing monkey-wrenches into the machinery. The requirement for good mental health is that each child be trained to adequate social conformity and self> discipline by example and by consistent methods adjusted to his individual ability, temperament, and state of maturity. Over-protection and pampering can be considered in the same way. Good mental health demands adequate independence and sense of responsibility. Over-protection is poor preparation for independence but pushing a fledgling out of the nest too soon may make him permanently frightened for life. The child's "toughening-up" for life must be done by suitable degrees.

It is by attention to general principles such as these that the nurture of children should be guided if they are to develop personalities that will be poor soil for mental illness.

In her daily work the public health nurse meets many situations in which she has opportunities to apply these general principles to individual cases. She may be confronted with an example of symptoms caused by fear in an over-protected child. She can either encourage the symptoms by showing concern or she can reassure the child by encouraging him and helping him to face his problem. She can discuss the situation with the teacher and parents and persuade them to follow the same policy. That sort of treatment may be called just common sense but common sense is often aided a lot by special knowledge and a scientific attitude. The sort of special knowledge that applies to problems of emotional adjustment and development can be called the Principles of Mental Hygiene. The public health nurse cannot do her day's work properly if she neglects these principles and it is in their broad application that the hope of making the soil resistant to mental illness lies.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Personnel Guidance

C. E. M. Rowles

In the field of business and industry today, the emphasis is on efficiency, and the ability to produce the greatest turnover in the least possible time. Many factors enter into this process, and not the least is the placement of personnel, particularly when the more responsible positions are vacant.

It has always been desirable that round pegs shall be fitted into round holes, and square pegs into square; but this rarely happens as the result of chance. As in the game where one is required to manoeuvre a number of little balls into a corresponding number of holes, so, in the placing of personnel, considerable skill is needed on the part of those responsible for selection.

The personnel manager of the business world is obliged to study his candidates from various angles. He has on his list applicants of many types, with radical differences of education, race, religion, background, and physical aptitudes. Often it is necessary that the individual be tried in several departments before his niche is found, and this is achieved by co-operation and discussion between various heads of departments. Not only is it necessary for the business or industry in question that each person be in a position to give of his best, it is also necessary for the individual to be placed in work he can do well, and which he enjoys doing, if he is to be an active happy member of society.

When the above rules are applied to nursing it is found that different conditions obtain. For example, although we are dealing with individuals who have various personal differences, yet we are also dealing with a group which has a certain similarity of background, education, and interests, often to the exclusion of outside influences. The fact that prospective nurses spend three years of their professional life within the walls of an institution, subjected to more or less stringent rules, results in the production of individuals who are more of a pattern than would be found in other groups, from the viewpoint of the personnel manager. Again, the period of training, while excellent from the professional viewpoint, has often done nothing to prepare the young nurse for her place in the world of affairs. with the result that, at the end of three years of sheltered life, she is suddenly plunged into a world where she has to stand on her own feet in competition with others.

The day has gone by when three years of basic training prepared a nurse for a lifetime's career. With the day of specialization upon us, we realize that the problem of personnel placement and guidance is with us to stay. Nursing also has changed, in that many fields are now open to the young graduate, which were unknown a few years ago. In spite of the avenues ahead of them, it is surprising how often a nurse

NOVEMBER, 1947

is found in a position which does not satisfy her, and which fails to give full expression for her aptitudes. The answer often lies in the fact that many nurses do not realize the scope of their profession; and others do not know how to prepare and apply for desirable and congenial positions.

That something concrete must be done about this problem is all too evident, and in many provinces and districts steps are being taken to provide some form of personnel guidance. Through this medium, many nurses have been guided into more suitable occupation, and have been encouraged to train for advanced and congenial work.

There are two main avenues along which personnel guidance may develop. The first is in the school of nursing where, during the third year of her training, the student nurse receives a course of "Professional Problems and Modern Trends in Nursing." Here it is possible to widen the viewpoint of the individual, and to provide her with a working knowledge of nursing as it exists in Canada today. It is a fact that all too many nurses are ignorant of the opportunities within their profession and, what is more deplorable, many lack the proper knowledge of Canadian nursing legislation.

At present, the majority of young graduates find employment waiting on the doorstep on the day of graduation. Unfortunately, it is often present in such variety that it is easy for selection to be made on a financial basis, rather than on the basis of congenial work, acquired experience, and satisfied instincts.

Through the members of the teaching staff, valuable guidance of personnel may be given. It is possible, through lectures and discussions, to make the nursing world more vivid to the students in training, and to guide them to the work for which they are best suited. Nobody knows the individual student as does her instructor, and personal interviews during the senior year help to clarify in the student's mind her confused

thoughts of the future. More preparation for the post-graduate world, with skilled direction, is needed by all young people venturing forth from institutions of learning, and particularly is this so in the case of young nurses who are called upon to take responsibilities far greater than those assumed by others of the same age group.

With the present demand for nurses it is often found that many members of the graduating class are re-absorbed into the hospital staff, usually as general staff nurses, sometimes as head nurses. In these cases it should be the aim of the director of nursing to see that these young women are not allowed to settle into a rut, even though that may be a tempting thought when one knows not whence the next nurse is coming. Often the nurse in question is not satisfied with her job, and does not know why. It may be something easily remedied, such as a transfer to another department or a change of shift; or it may be that the nurse has ambitions for more advanced work, but cannot see how she will ever be able to prepare for it.

Personal interviews, conferences, and staff education will give each nurse the opportunity to decide for herself what type of work she prefers. Experience may be found close at hand, or it may be necessary for her to study at a distant university. Whatever the outcome may be, the member of the staff, who is acting in the capacity of adviser, must herself be well informed and capable of giving helpful and practical advice to others.

By this means many young nurses may be guided into more congenial positions, and others stimulated to prepare themselves for such positions by advanced study. Often it is necessary that financial aid be obtained before university courses are taken, and here the adviser may bring to the attention of the nurse various bursaries and scholarships that are now available. Sometimes we find that the nurse is reluctant to apply because she feels that she has no chance of success; and sometimes she

is uncertain how to submit an application. The wise director is on hand to

advise, help, and encourage.

The alternative pattern in this work is planned for the older group of graduate nurses. In some of the provinces, placement bureaux are playing an important part in personnel guidance. Through the medium of the bureau, which acts as an impersonal agent between employer and employee, many nurses are finding the positions they have always wanted, and directors of nursing service are able to fill vacant positions with suitable candidates.

The director of the bureau has an arduous task, especially as so much of the placement has to be done by correspondence, rather than by personal interview. Even where the interview is possible, it is often difficult in the short time available to assess the individual's merits justly and impartially, and more difficult to remember the facts clearly. nurse's file, containing personal data, references, and details of training, experience, etc., should prove to be an invaluable aid in placing the applicant: but it does not provide that insight into character which is essential.

Where the placement bureau serves a city and its environs, it is often possible for personal interviews to be arranged with all applicants. This gives the director a more complete picture of the nurse who is seeking employment, especially if that director is a person of insight, capable of seeing beyond the tremors of a nervous applicant. It is not always possible for the director to go to the nurses of her district, but they should be encouraged to come to her, and to know her as a friend. References, although valuable, tend to be formal and non-informative and, when provided by friends, are not always to be Therefore, it seems relied upon. that the director of the placement bureau should be provided with ample time and opportunity to judge her applicants, if she is to guide them efficiently.

At this time when unemployment is unknown among nurses, it might seem that this plea for personnel guidance is unnecessary, but how much better if we could say that all nurses are employed in the positions best suited to them, rather than the bald statement: "All nurses are em-

ployed."

In Memoriam

Hazel (Darker) Buckland, who graduated from the Sherbrooke Hospital in 1925, passed away recently at Island Brook, Que.

Agnes Coburn passed away in London, Ont.

Lylian Audrey Hurd Knowles, who graduated from the Saskatoon City Hospital in 1928, died in July, 1947.

Christy A. MacKay, who was one of the first graduates of the Montreal General Hospital, died on July 28, 1947, in her ninetieth year. Miss MacKay spent most of her active years in the nursing profession in Montreal.

She spent several months overseas as a private nurse to Lord Strathcona.

Edith McCausland, a graduate of Victoria Hospital, London, Ont., died there in July, 1947, after an illness of five months.

Velma (Coote) Morkill, who graduated from Sherbrooke Hospital in 1935, died in Megantic in her thirty-fifth year.

Eva A. Ross, aged thirty-five, a graduate of Soldiers' Memorial Hospital, Orillia, Ont., passed away following an operation. For some time Miss Ross had been employed as an office nurse in North Bay, Ont.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Enseignement Chez les Malades

SUZANNE GIROUX

Dans les recommandations faites par l'Association des Infirmières du Canada sur le choix d'une bonne école d'infirmières, on lit: "Il est absolument nécessaire que les heures d'enseignement pratique dans les salles soient faites sous surveillance. Cet enseignement doit comprendre des conférences, des cliniques aux lits des malades, et de l'enseignement particulier. Cet enseignement doit être

donné par des institutrices."

Si l'on veut être sincère l'on conviendra que les heures de travail sur les étages ne peuvent être considérées comme de l'enseignement pratique, à moins qu'une institutrice ou plus, selon le nombre d'élèves, enseigne aux élèves, en plus de bien travailler, l'application de ce qu'elles ont appris en classe, qu'elle les aide à mieux observer, à mieux analyser, à mieux comprendre le malade. Il faut que le travail sur les étages "soit une série d'expériences progressives tellement contrôlées, reliées entre elles et unifiées que ce que l'on apprend d'une expérience serve à l'interprétation, à l'agrandissement, et à l'enrichissement des expériences qui viendront par la suite." En d'autres mots, une expérience nouvelle doit faire appel à toutes les expériences passées (enseignement théorique, histoire de cas, malades traités) pouvant aider à mener à bonne fin cette nouvelle expérience.

Si l'on veut être sincère, l'on conviendra également qu'il est impossible de demander à l'hospitalière, qui a l'administration et la surveillance du département, de donner cet enseignement. Il est d'ailleurs démontré que

si l'on veut que cet enseignement soit donné avec succès, que l'on ne doit pas demander à l'infirmière, qui est obligée de faire exécuter le travail du département, de donner cet enseignement. Son intérêt serait divisé entre les besoins du service et les besoins de l'école.

En plus, cet enseignement chez les malades doit être donné par une institutrice de carrière. L'hospitalière doit prendre part à cet enseignement en co-opérant étroitement avec l'institutrice, en aidant à la préparation et à l'exécution du programme.

Une fois convaincu de la nécessité et de l'urgence de l'enseignement chez les malades, la première chose à faire est de nommer une infirmière en charge

de cet enseignement.

Choix de la Directrice du Programme

Cette infirmière devra être convaincue de la valeur d'enseignement clinique. Elle doit être une institutrice ayant une certaine expérience dans l'enseignement. Son travail sera d'enseigner, soit en donnant des cliniques, des démonstrations dans divers départements, soit en observant l'enseignement donné par l'hospitalière, son assistante, et les autres infirmières diplômées. Il ne faut pas oublier que l'enseignement par l'exemple a toujours une grande valeur.

PROGRAMME

Le programme devra être préparé par la directrice des études et l'infirmière en charge de l'enseignement chez les malades, puis présenté aux hospitalières pour étude. Une fois le programme corrigé et adopté, il doit être exécuté. Le but que l'on se propose doit être bien défini, rien de vague, comme une meilleure formation de l'infirmière, etc.

Chacune doit prendre part à l'exécution de ce programme — institutrices à l'école, hospitalières, infirmières diplômées, élèves, travailleuses sociales, etc. L'enseignement doit être démocratique, chacune peut dire son mot, apporter son idée.

Inutile de vous dire qu'il doit y avoir suffisamment de malades et de

Le personnel de l'étage doit être suffisant pour permettre à un groupe d'élèves de se retirer dans une petite salle, un salarium, contenant des chaises, un tableau et discuter sur les malades qu'elles viennent d'observer, sur la solution qu'elles viennent de préparer, sur la cause sociale indirectement responsable de l'état de ce malade, sur quels moyens psychologiques à employer pour avoir la co-opération de ce malade, etc.

Durée du Cours

Dans son manuel sur l'enseignement chez les malades (Ward Teaching by Anna M. Taylor: J. B. Lippincott Co., 2083 rue Guy, Montréal) il est dit que les cours devraient être de 2½ heures par semaine, donnés soit en cinq périodes d'une ½ heure,

ou encore en trois périodes d'une ½ heure et trois de vingt minutes.

L'heure la plus convenable peut varier selon les départements. En Angleterre durant la guerre, l'enseignement clinique se donnait régulièrement au London Hospital à raison d'une heure par jour, tous les matins.

L'institutrice tiendra compte des leçons données, du département, et si les leçons ont été omises pour quelle raison. L'élève tiendra aussi compte des leçons reçues.

La détermination et la persévérance ne sont pas moins nécessaires que la préparation et l'expérience de l'institutrice et de la préparation du programme — détermination et persévérance pour surmonter les obstacles, pour vaincre la routine, pour démontrer la nécessité de cet enseignement, pour obtenir le temps, l'espace et les élèves.

Je crois que l'effort en vaut la peine et que, par ce moyen, nous développeront encore davantage chez l'infirmière, l'intérêt envers le malade.

RÉFÉRENCES

- Un Supplément au Programme d'Etude à l'Usage des Ecoles des Gardes-Malades du Canada.
- 2. Ward Teaching: Anna M. Taylor. J. B. Lippincott Co., Montréal.
- 3. Notes de cours: M. Lindeburgh, Université McGill. Soeur St-Louis, Institut Marquerite d'Youville.

Swelling of the Arm

By far the most important factors in the production of swelling of the arm following radical mastectomy are infection and x-ray dermatitis. Primary skin grafting has no influence on the occurrence of swelling. Furthermore, this swelling cannot be assumed to signify a recurrence of the carcinoma. The presence or absence of metastasis to axillary nodes at the time of operation has no bearing on the condition.

After swelling of the arm has developed the treatment is unsatisfactory. Conservative measures such as suspending the arm at night, gentle massage, and rest are rarely of lasting benefit. Some patients state that use of the

arm increased the swelling, but a few stated that the swelling diminished after use.

The best treatment for this swelling is prevention. It were effect should be made to secure primary wound healing and to prevent the collection of serum under the flaps. All possible precautions should be taken to avoid roentgen-ray dermatitis by discontinuing therapy before ulceration appears. Extreme care should be taken to avoid even minor wounds and infections of the hands. When present these should receive prompt attention. It is important to warn these patients that the appearance of swelling does not mean a recurrence of their original disease. Surgery

Nursing Profiles

Lillian Ethel Pettigrew, who for several years has been health instructor at the Winnipeg General Hospital, has been appointed executive secretary and registrar of the Manitoba Association of Registered Nurses. Miss Pettigrew brings to her new work a very broad and comprehensive understanding of present-day nursing problems. Graduating from the Winnipeg General Hospital in 1931, after a few months in private duty she was named as assistant to the executive secretary of the Canadian Nurses' Association and for seven years was in a key position to become familiar with nursing affairs throughout Canada.

The recipient of a scholarship from the Quebec provincial nurses' association in 1938, Miss Pettigrew qualified in public health nursing at the McGill School for Graduate Nurses and joined the staff of the Victorian Order of Nurses in Toronto. During her residence in Ontario, Miss Pettigrew took an active part in nursing association activity and was convener of the Public Health Section, District 5, R.N.A.O. She served as president of the M.A.R.N. for two years subsequent to her return to Manitoba in 1943. At the 1946 convention of the C.N.A., she was elected honorary treasurer. We all wish Miss Pettigrew great success in her new undertaking.



Davidson Studio, Winnipeg

LILLIAN PETTIGREW

Jenny McMartin Weir, B.Sc., M.A., has taken up her duties as lecturer in public health nursing at the Queen's University School of Nursing. Miss Weir graduated in 1941 from the University of Alberta Hospital. Following the completion of her university work, she joined the staff of the Metropolitan Health Committee, Vancouver, where she served until her enlistment as a nursing sister with the Royal Canadian Air Force in 1944. Miss Weir has recently completed the work for her Master's Degree in supervision in public health nursing at Teachers College, Columbia University.

Perhaps it was her experiences in the services which gave her the desire to learn to fly. Miss Weir hopes to secure her pilot's licence eventually. She is a skilled pianist, loves reading, dancing, and swimming. Our good wishes go with her as she commences her new activity.

Florence H. Martyn, B.Sc., who graduated from the Royal Alexandra Hospital, Edmonton, in 1915, has taken over the duties of superintendent of the nursing services in Bengal, India. Miss Martyn secured her certificate in midwifery in Ireland in 1917 and her degree from St. Joseph College, Hartford, Conn., in 1944.



Krass, Vancouver

JENNY WEIR

After over two years of missionary service in India under the auspices of the Church of England, Miss Martyn developed tuberculosis in 1920. During the "cure," she became especially interested in the work of medical laboratories. She has had extensive experience in this field in many parts of the world, her road finally leading her back to India. We wish her success and happiness in the expanding field of endeavor she has undertaken.

Ann Isobel Black, B.Sc., has been named assistant superintendent of the Victorian Order of Nurses for Canada. Six of the eleven years since she graduated from the University of Alberta Hospital, Miss Black has seen service with the V.O.N, in Winnipeg, Victoria, Hamilton, and Niagara Falls. For three years she was health instructor at the Winnipeg General Hospital and since 1944 has been in charge of the public health nursing course at the University of Manitoba School of Nursing. Miss Black has a thoughtful and progressive outlook on public health nursing and is well equipped to give leadership in her new work.

Olga Drover, a native of Newfoundland, who graduated from the Toronto General Hospital in 1943, has been appointed field nursing supervisor with the Newfoundland Tuberculosis Association. Following her graduation, Miss Drover spent some months in charge of the obstetrical department of Grace Hospital, St. John's. In the summer of 1944 she responded to the urgent appeal for nurses in England and took up active duty at the Emergency Casualty Hospital, Leatherhead, Surrey. This hospital was used as an evacuation centre for the wounded of London's flying bomb raids. Returning to her home in Newfoundland in late 1946, Miss Drover has been engaged with the Department of Public Health and Welfare.

Phyllis Wightman, whose varied nursing career since she graduated from St. Joseph's Hospital, Victoria, in 1924, has been full of interest and activity, has joined the staff of the Vancouver Children's Aid Society to be responsible for the health of the children who are wards of that organization. Miss Wightman joined the operating-room staff of her home hospital following graduation. For three years she was assistant matron of the Queen Alexandra Solarium, and for four years was supervisor and later acting matron at the King's Daughters Hospital, Duncan, B.C.



Imperia State Handle

ISOBEL BLACK

Private duty experience has also contributed to her professional background for her new work. In her spare time Miss Wightman specializes in knitting and leathercraft.

Dorothy May Behrendt, a 1942 graduate of Royal Columbian Hospital, New Westminster, has been appointed superintendent of nurses of the Ladysmith (B.C.) General Hospital. Since her graduation, Miss Behrendt has been engaged in general staff nursing at the Nanaimo General Hospital; later she served in the surgery. Miss Behrendt is fond of reading and dancing though she draws the line at modern jive. Horseback riding is her favorite outdoor pursuit.

Alice Ethel Bingeman, a native of Bloomingdale, Ont., who graduated from Roosevelt Hospital, New York, in 1917, and who has been lady superintendent of the Freeport Sanatorium, Kitchener, Ont., for the past twenty-four years, has retired. Presentations



ALICE BINGLMAN



LYNETTE GUNN

were made to Miss Bingeman at the reception held in her honor, together with tribute to her unswerving loyalty and devotion to duty. Ill health occasioned by staff shortages during the war years forced Miss Bingeman's retirement before she had reached her cherished goal of a quarter of a century of service to the San. The *Journal* joins her many friends in wishing Miss Bingeman a speedy return to health and many years of happiness.

Lynette Gunn has resigned after seventeen years' service with the Victorian Order of Nurses in Winnipeg. Miss Gunn graduated from the Winnipeg General Hospital in 1920 and after a brief period of private duty in Manitoba and California went to New York and engaged in social service work. Upon her return to Winnipeg she joined the staff of the V.O.N., later becoming a supervisor, then assistant superintendent. Ten years ago she took the post-graduate course in public health nursing at the McGill School for Graduate Nurses.

Miss Gunn has been president of the W.G.H. alumnae association for the past two years. She is a member of the Business and Professional Women's Club. She is immensely proud of the certificate which she received from the Dominion Government for devotion to duty on the home front during the war years. Though she has retired, Miss Gunn intends to be active. "People," she has said. "no matter who they are or where they come from, are always interesting." With this as her motto Miss Gunn will find rich happiness in the years that lie ahead.

Canadian Nurses' War Memorial

(Continued from page 828)

all of them. If you wish to go farther afield, the public and reference libraries are also at your service. Do we not rather take it for granted now, that books will be available? How would we feel if these professional books were not on the shelves ready for us just to reach up and take the ones we need? Have we stopped to think that there are many, many nurses in Europe who have no nursing textbooks and no proper schools or classrooms in which to teach the young student nurses whom their countries so urgently need?

At the biennial convention of the Canadian Nurses' Association in Toronto in July, 1946, it was decided that the Canadian Nurses' War Memorial would take the form of the establishment of a nursing library or libraries in one or more of the countries whose libraries were destroyed by enemy action during the war. Personally I think of our Canadian Nurses' War Memorial as a tribute to all nurses for the work done during the war, when the many added demands were carried

out so willingly by nurses in every branch of nursing throughout the world.

Some of you may not think it necessary to create a memorial. Whether in accord with the Canadian Nurses' Association on this subject or not, we must surely all agree that the world does need positive human relations of mutual aid and especially of assistance to the distressed and ravaged countries. There has been a vast uprooting of humanity, so widespread that we here in Canada, in one of the most favored parts of the world, have little realization of its extent. In what better way could we, the nurses of Canada, give assistance to European nurses who have shown such courage and fortitude, than by supplying them with professional books to enable them to rebuild their nursing libraries and their nursing profession?

Sure there is need of social intercourse, Benevolence and peace and mutual aid Between the nations in a world.

-AGNES C. NEILL in R.N.A.O. News Bulletin

Notes from National Office

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association will be held at the University of Alberta, Calgary, December 5-6, 1947. On the two days immediately prior to this meeting a registrars' conference will be held at the School for Nursing Aides on the University of Alberta Campus, Calgary. This is the second such conference of the provincial executive secretaries and it is felt that this sharing of experiences is a most valuable factor in co-ordinating the various nursing activities across Canada.

The 1948 Convention

A special invitation is extended to schools of nursing all across Canada to plan to have at least one member of their student body attend the 1948 biennial convention of the Canadian Nurses' Association in Sackville, N.B., next summer. There is no more positive way to develop a healthy interest in association activities among the student nurses of Canada than by encouraging them to familiarize themselves with the full program of nursing through attendance at these conventions. It is suggested that the most effective means of stirring up this interest is where the student body raise the necessary money themselves to send their representative. Start planning now to have one member from your school present. If a sufficient number of schools are represented, it should be possible to incorporate some special features in the program to interest the student nurses especially. Let us know what you are planning.

Nurses' Interests

At a meeting of the Executive Committee, C.N.A., held on April 30, 1947, the chairman of the Program Committee for the 1948 biennial meeting informed the members of the executive that a large number of replies has been received to the questionnaire sent to nurses, through the provincial nurses' associations, for the purpose of determining their interest in establishing travelling institutes or refresher courses, and also to determine the subject for such course. It was felt that the workshop discussion plans for the next biennial meeting might assist in determining the nature of the course to be given and that implementation of this program might, therefore, be delayed until after that time.

The following motion was unanimously carried by the Executive Committee:

That the carrying out of the program of travelling institutes be delayed until after the 1948 general modeling

British Nurses Relief

A letter received recently from the general secretary of the Royal College of Nursing, conveying the deep gratitude felt by all the members for the help and encouragement they have received from their colleagues in Canada, reads as follows:

You will remained I told you of the ideas the Council of the Royal College of Nursing had for utilizing the residue of the Civilian Nurses Air Raid Victims Funds. How they planned to allocate £5,000 to the Rest-Breaks service, leaving a certain amount to help those nurses, who, being permanently incapacitated, would still require

some assistance in addition to their State allowance. This has been done, and I am sure you will be glad to know that we have been able to purchase annuities for four nurses permanently disabled so that they will be relieved of financial worries for the rest of their lives. Others, unable to continue active nursing, have been retrained as social service workers, occupational therapists, almoners or teachers, and have benefitted immensely through the generosity of our colleagues in the Dominions.

As to the Rest-Breaks Houses, Her Royal Highness, Princess Alice, when officially opening Barton House Hotel on April 30, 1947, alluded particularly to the help that had come from the nurses of Canada for this project and in commemoration she planted a maple tree specially flown from Canada for this purpose. Contrary to all horticultural advice (for the tree was planted in the spring instead of the fall) it has taken good root and is flourishing. So there is a real living piece of Canada in the gardens of Barton House - a token of the friendship which exists between our two countries. We trust that as it flourishes and grows into a big tree, it may symbolize the growth of unity and friendship between

The main object of this letter, however, is to try to express our thanks to our Canadian colleagues for all that they have done and are doing to help us. For months past gifts of all kinds - food, soap, quilts, rugs, blankets, etc., have flowed into Great Britain and in addition yards and yards of very beautiful chintz and other material to provide curtains (or drapes, as you call them) for the Rest-Breaks House and annex. The rooms thus furnished, one being the diningroom, are perfectly delightful and all the visitors tell me how much they enjoy the color scheme and what a change it is from the prevailing austerity which we have to put up with in our homes.

It is impossible for me to tell you in so many words just what all this means to us but I hope that if any members of the Canadian Nurses' Association are in England they will visit Rest-Breaks House to see for themselves and will have a look at the special book which is kept there for recording gifts to the House.

It may interest you to have an extract from a recent letter from the Warden at Barton House about the guests who stay there. She says:

"The majority of our guests at present are middle-aged, and a good many are over sixty but there is a sprinkling of young student nurses. About one in twenty are matrons and others a mixture of sisters, staff nurses, midwives, district nurses, health visitors, and private nurses. Roughly about half are living in hospitals.

"They come chiefly for 'Rest-Breaks' and 'Post convalescence' as apart from holiday rests, and quite a fair proportion are recovering from serious operations.

"We find they arrive looking tired and often feeling the effect of climbing stairs for the first few days. After that, they seem to improve and brighten up to a remarkable degree. They are unanimous in their approval of Barton House, and the benefit they derive from their rest, also the wonderful air of Barton-on-Sea."

A constant and very welcome stream of food parcels have also been arriving at the College and it is our happy duty to distribute these to the nurses whom we feel are most in need of them. For one reason or another, probably the aftermath of war and overexertion, everyone seems to complain of a great feeling of fatigue and many matrons tell me how often their student nurses complain of being tired. You will see, therefore, how helpful it is (a) to have a Rest-Breaks House to send them to and (b) to have these wonderful food parcels containing so many nourishing and stimulating articles. When distributing, we allocate them to four main categories: (1) elderly nurses; (2) nurses living alone and doing health visiting, domiciliary, or industrial nursing (these find it very difficult to manage on their rations); (3) those ill in hospitals or infirmaries; and (4) such places as the College Rest Home at Bonchurch, Isle of Wight, and Rest-Breaks House at Barton, where such an addition to the larder is a perfect godsend. By every post I am sure some Canadian nurse must be receiving a happy letter from the recipient of one of these parcels and here are a few remarks from letters which I have selected at random:

"Thank you for the lovely parcel which arrived safely this morning. I will certainly gain a few pounds in weight after enjoying its contents. Our colleagues in the Dominions have certainly been very generous providing us with such grand parcels. It is good to know that we have such kind friends in other countries, ready to lend

a helping hand in these hard times."

"This is the first parcel of any kind I have ever received, from overseas or anywhere, to help relieve my distress and I am most grateful to you and the giver who will soon receive my letter of thankfulness."

"The parcel came at a very nice time. I have an elderly nurse staying with me while she is changing her posts and when we opened it, well, our eyes danced! We had the sardines with bread and butter for our first course for dinner, then the tin of damsons with part of a milk pudding from the day before for our sweet, and then a nice cup of special tea and a slice of cake. Not even the Queen could have enjoyed her dinner more. It is not just the money value but they are things which make just the break from the daily round, so while we ate our meal we laughed and chatted and wished the dear nurses who had sacrificed things to give us this pleasure could have seen us."

"The parcel contains twenty-one tins or packets, practically all of which would be goods on points, or rationed over here. Apart from the impossibility of ever being able to queue for any little extras, many of these dainties would be quite impossible to find over here. I am writing at once to express my appreciation. As I am one of those who must take a packed lunch every day, I am more than ever grateful for this particularly generous and skilfully thought out gift. With very many thanks."

"I have just been ill and am only just beginning to feel myself again. Thank you very much indeed for the wonderful parcel which I received at the week-end. It was such a thrill unpacking it all and seeing what a variety of things there were. It was lovely and much appreciated."

"Many thanks for the gift parcel from Canada with such enjoyable contents. It does cheer one up to be remembered so kindly by you and friends abroad. God will reward and bless all such."

You will gather what a very real difference not only the kind gifts but the warm thoughts from Canada have made in the lives of British nurses.

And now for the future. Having got Barton House into running order, we are looking around for a similar property in the north of England, so that nurses from Scotland and the north can have a Rest Home without having a long and unpleasant journey to get there. This may take some little while especially as we shall have to get together something in the region of £30,000. We have a small nucleus of money already towards this and I expect before long to be able to report good progress to you.

Greek Nurses

"We wish to acknowledge having received from you a further donation of used shoes for the State School for Nurses in Athens, Greece. In this connection, we wish to quote from a letter which we have received from the Greek Red Cross:

"Will you please convey to the Canadian Nurses' Association our thanks for their kind gift, and let them know that we accept with pleasure hoping that, although used, these shoes will be useful to their colleagues in Athens."

Notes du Secrétariat de l'A.I.C.

LE COMITÉ EXÉCUTIF DE L'ALC.

Le comité exécutif de l'Association des Infirmières du Canada se réunira à l'Université de l'Alberta, Calgary, le 5-6 décembre 1947. Deux jours avant cette assemblée les registraires se réuniront en conférence à "School for Nursing Aides" (l'Ecole des Aides) située sur les terrains de l'Université de l'Alberta, Calgary. C'est la seconde fois que les secrétaires provinciales se réunissent en conférence, et l'on croit qu'en partageant dans ces réunions les expériences des unes et des autres. l'on a trouve là un excellent moven de co-ordonner les diverses activités du nursing au Canada.

II CONGRES DE 1918

Une invitation speciale est adressee à routes

les écoles d'infirmières du Canada de se préparer à envoyer l'été prochain au moins une de leurs élèves au congrès biennal de l'A.I.C. en 1948 à Sackville, N.B.

Il n'y a pas de moyen plus efficace pour développer chez les élèves infirmières du Canada un intérêt vivace dans le travail accompli par les associations, qu'en les familiarisant avec toutes les questions du nursing par l'assistance aux congrès.

Il est suggéré, comme un excellent moyen de créer de l'intérêt, que les élèves trouvent elles-mêmes l'argent nécessaire pour envoyer leur représentante. Préparez-vous dès maintenant à avoir une représentante de votre école au congrès. Si un nombre suffisant d'écoles ont une représentante des choses intéressant tout particulièrement les élèves infirmières seront mises au programme. Faites-nous connaître vos plans.

Aide aux Infirmières de Grande-Bretagne

Une lettre reçue dernièrement de la secrétaire du Collège Royal des Infirmières transmet un message de reconnaissance de tous les membres qui ont reçu de leurs consoeurs du Canada, de l'aide et de l'encouragement:

"Vous vous rappelez que le Conseil du Collège Royal des Infirmières avait eu l'idée d'employer £5,000 (partie du résidu de la souscription faite pour venir en aide aux infirmières civiles victimes des bombardements) à des maisons de repos pour infirmière, ce qui laissait une certaine somme permettant d'aider les infirmières souffrant d'incapacité permanente, qui n'avaient que la pension que leur verse l'Etat. Celà a été fait et vous serez heureuses d'apprendre qu'il a été possible d'acheter des rentes viagères pour ces infirmières qui n'auront plus d'inquiétudes d'ici à la fin de leurs jours.

"D'autres, dont les infirmités ne leur permettaient plus de continuer à soigner les malades, ont été préparées à remplir des emplois en occupation theurapeutique comme travailleuses-sociales, économes, institutrices — toutes ces personnes ont bénéficié grandement de l'aide apportée par les infirmières des Dominions.

"Dans les maisons de repos, lors de l'ouverture officielle de l'une d'elles, Barton House Hotel, en avril dernier, la Princesse Alice mentionna tout particulièrement l'aide apportée par les infirmières du Canada et en souvenir de cet entr'aide planta un érable qui avait été transporté par avion du Canada pour cette occasion. Contrairement aux prévisions des horticulteurs (l'arbre a été planté au printemps plutôt qu'à l'automne) l'érable a pris racine et pousse bien."

La lettre se continue, exprimant toujours une grande reconnaissance et le bien que notre aide fait à ces infirmières qui joyeusement ont supporté les privations durant toute la guerre, espérant qu'avec la paix un peu de l'abondance du passé leur reviendrait et qui se voient encore privées, plus que durant la guerre, de nourriture de vêtements, de transport de charbon, etc.

Nos envois sont un ravon de soleil dans leur vie triste et un réconfort physique et moral. Les directrices des hôpitaux rapportent que les élèves se fatiguent facilement, qu'elles sont plus sujettes aux maladies. Les maisons de repos, où elles peuvent faire de courts séjours, leur permettent de refaire leurs forces. Le message se continue: "Les colis de vivres, adressés au Collège Royal des Infirmières, sont distribués comme suit: (1) Aux infirmières agées; (2) aux infirmières visiteuses vivant seules (il est très difficile de se débrouiller avec une seule ration); (3) aux infirmières dans les hôpitaux et dans les infirmeries; (4) et aux maisons de repos où tout surplus à leur ration est considéré comme un bienfait du ciel."

Des extraits de lettres reçues d'infirmières, remerciant pour des colis, montrent la joie, la reconnaissance et l'utilité de ces dons. J'en prends une au hasard: "Votre colis arrive au bon moment. J'ai une infirmière agée qui demeure avec moi pour quelque temps. En ouvrant votre boîte, nos yeux ont brillé de joie. Au dîner nous avons mangé des sardines avec du pain et du beurre, puis pour dessert nous avons ouvert la boîte de prunes. Nous avons fini notre repas par une tranche de gâteau et en buvant une bonne tasse de thé.

"Nous aurions voulu que l'infirmière qui a envoyé ce colis nous voit durant notre repas, nous avons causé, ri, comme si une fête avait interrompu notre routine journalière. Ces colis ont plus qu'une valeur matérielle—vos sacrifices nous donnent du bonheur."

DES FAITS INTÉRESSANT LES INFIRMIÈRES

Lors d'une assemblée du comité exécutif de l'A.I.C., tenu le 30 avril 1947, la convocatrice du comité du programme pour le congrès de 1948 informa les membres du comité que l'on avait reçu un grand nombre de réponses au questionnaire envoyé aux infirmières par les associations provinciales, afin de savoir si

elles seraient intéressées à suivre des courpost-scolaires et à assister à des conférences et aussi afin de déterminer sur quel sujet devraient porté ces cours.

L'on pensa que les discussions, lors des réunions des divers cercles d'étude au congrès biennal, seraient de nature à déterminer les cours à donner et que par conséquent l'exécution de ce programme pourrait être retardé jusqu'après le congrès.

Le résolution suivante fut adoptée à l'una-

nimité par le comité exécutif:

"Que l'exécution du programme des cours donnés par une institutrice ambulante soient retardés jusqu'après le congrès de 1948."

LES INTERMIÈRES DE GRÉCE

Les intermières de Grèce remercient pour les chaussures reçues et demandent que les envois de chaussures usagées soient continués.

A Model Nurses' Home

MARGARET LAWRENCE

USTRALIA's newest and most up-A to-date hospital, the Royal Melbourne, houses its four hundred nurses in a streamlined ten-storey building which provides all the conveniences of a modern hotel and all the comforts of a private home. Realizing the important part that living conditions play in promoting efficient service, the architects took special pains to provide comfortable and attractive quarters for the nursing staff. Completed in 1942 and known as the Charles Connibere Memorial Nurses' Home, it stands apart within the hospital grounds.

Student nurses accepted for the three-year general course at the Royal Melbourne Hospital begin their careers in ideal conditions. fresh from school - many of them from the country and rather timorous about embarking on a career — are reassured by the friendly atmosphere. They find that the person in charge of the nurses' home is kindly and warm-hearted and they quickly learn to take all their problems to her. Also they are able to "find their feet" and make friendships among themselves before they need mix much with the more advanced student nurses and graduates.

As they settle down they begin to take more part in the activities of the Student Nurses' Representative Council, the elected body which looks after their interests in the management of the nurses' home.

Some of the senior graduates who have worked in many hospitals in several countries were recently discussing the remarkable absence of bickering among the staff, which is usually considered inevitable when large numbers of women are living together. They decided it was due partly to the size of the building, which allowed all the girls to get away by themselves when they felt



(. . fr)

Each nurse has her oven bedroom



Comm. of Aus. Photo Equipped kitchenette

inclined, and partly to the architects' forethought in planning.

At the Royal Melbourne, there is never any occasion for the sort of tension that develops when someone else has taken the only copy of the daily paper or got in first with the only comfortable chair in the common room or the only drying line for the washing. Every opportunity for a full and enjoyable social life is provided by the many pleasant sittingrooms. Concerts and formal entertainments are held in the restful and



Comm. of Aus. Photo Hairdressing salon

spacious lounge on the ground floor.

Easy chairs, abundant flowers, attractive pictures by modern Australian artists, wide window-space, including the length of one whole wall, combine to create an atmosphere of comfort and charm. In addition there are cosy smoke-sitting-rooms on each floor.

The nurses share the dining-room in the main hospital building with the rest of the resident staff, but the kitchenettes adjacent to the smoke-sitting-rooms are very popular for casual snack meals and suppers. Each kitchenette is equipped with a refrigerator and electric kettle, griller and toaster, and there is plenty of cupboard space for the girls' own dishes. A practical device is a rubbish chute near the kitchenette which removes rubbish from all floors to a furnace in the basement.

On the ground floor are the music room and the reading and writingroom, where copies of the daily papers are provided. The nucleus of the growing library was purchased with funds raised by a concert given by the student nurses some years ago.

In too many hospitals, nurses complain that they have nowhere to entertain their friends. At the Royal Melbourne there are five visitors'cubicles, attractively furnished in a brown and fawn color scheme, where they can serve their guests with refreshments.

Just about the most popular room in the nurses' home is the milk bar, which is packed at all hours of the day with girls wanting a quick snack. Here, in dressing-gowns, slacks or housecoats, they can nibble a slice of toast while reading the paper, or enjoy a morning snack of ice cream, sandwiches, fruit or milk drinks, or whatever they fancy. Cost price only is charged.

As the new Royal Melbourne Hospital was completed at a time when building was restricted to absolute essentials, no provision for games was made. But future building plans for the hospital include three tennis courts, squash courts, and a recreation hall-gymnasium. As it is, the



Communication of An india Protect

Milk Bar in Nurses' Home

nurses are not far from tennis courts and other sports grounds.

The sleeping quarters show the same thoughtful consideration for the nurses' comfort as the social rooms. Each girl has her own bedroom, uniformly furnished in oak, and takes a pride in expressing her own individual tastes by the addition of her favorite flowers, photographs, and decorations. There are about forty bedrooms on each floor, and one bathroom to each four nurses.

Staff on night duty occupy two floors. Graduate and student nurses in different years of their courses also occupy separate floors, so that girls have the advantage of bedrooms near those of their own friends.

Laundering of uniforms is done by the hospital, but on each floor there is a laundry, complete with tubs, hot water service, electric irons and drying cupboards, in which the nurses can do their personal washing.

Examples of the practical way in which the nurses' leisure hours are provided for by the hospital planners are the sewing room, equipped with a power machine and a dressmaker's dummy; the hair-dressing salon, run by a private firm, and the hair-dressing room, equipped with electric dryers.

Another feature is the music room, in which nurses can indulge their fancy for boogie-woogie at the piano without disturbing those who are listening to a broadcast of a symphony concert in the lounge.

The nurses' home has its own office, which is open until 11 p.m. Here nurses can collect mail from their own letter boxes, post letters, send telegrams, buy stamps, have parcels left, make telephone calls, and so on. The switchboard transfers calls to telephone extensions on each floor.

Not all nurses find their living conditions as congenial as those at the Royal Melbourne Hospital; but as new hospitals are built and old ones remodelled, nursing quarters designed on modern lines will provide happy home surroundings for all nurses.

Vitamin Lack Affects Eyes

If your eyes tire easily, are watery and uncomfortable, and you suffer from headaches, the trouble may be that you are not eating enough riboflavin, or vitamin B₂. Investigations show that persons receiving an insufficient supply of this vitamin show changes in

the small blood-vessels at the surface of the eyes, and the remedy is to eat more of such meats as liver and kidney, as well as of cheese, eggs, wheat germ, beans and pers. Milk also is rich in vitamin B₂.

Health News

Food Poisoning

M. MITMAN, M.D., F.R.C.P., D.P.H.

T is popularly believed that food which does not smell or taste spoiled is safe for eating. This is a fallacy: dangerously contaminated food may appear quite wholesome. The case is reported of a Belgian sanitary inspector who was asked to examine some sausage thought to have caused illness among workmen. He was so satisfied with the excellent appearance, good color, and smell of the sausage that he pronounced it good and ate some to prove its harmlessness: he was dead of food poisoning within a week! On the other hand, food undergoing putrefaction may be unpleasant to the smell and taste but does not necessarily, or even ordinarily, produce substances capable of causing human food poisoning. Limburger cheese and high game are both undergoing putrefaction but are not poisonous. It is worth mentioning that the term "ptomaine poisoning" has been abandoned. The word "ptomaine" comes from a Greek word meaning "corpse" and was used to denote toxic substances arising in putrefying food. Chemically the word is meaningless, and is never used by those with knowledge of food poisoning.

How Food Poisoning can be Caused It was once widely believed that tin, aluminum, copper, and nickel in utensils or cans were capable of causing poisoning. In fact, however, in the form in which they appear in the kitchen they are not dangerous, and chemical food poisoning is rare. There have been examples of antimony in cheap grey enamel causing trouble and of cadmium in plated metal containers getting into acid foods prepared in them, but as soon as manufacturers had their attention drawn to these things they were eliminated. Certain metal polishes and cleansers containing cyanide are, however, poisonous and must not be used in the kitchen. Instances have occurred of harmful chemicals getting into food in mistake for other substances. Sodium fluoride, a poisonous chemical sometimes kept in the kitchen and used for killing cockroaches, resembles baking soda so closely in appearance that it has been used in error with serious results.

Everyone is familiar with the danger of consuming poisonous fungi in mistake for edible mushrooms; but it is not so widely known that rhubarb leaves which contain a poisonous chemical, oxalic acid, were used in the first world war as substitute for

spinach!

Shell-fish may cause trouble in a number of ways. Outbreaks of mussel poisoning have been reported due to poisonous food (plankton) consumed by the mussels themselves; but most shell-fish poisoning is due to one of two other causes: either it is due to hypersensitivity of the consumer to perfectly clean, wholesome fish, and is not poisoning in the strict sense at all, but is rather an "allergy," or is due to organisms which reach the shell-fish beds from sewers.

Much the commonest causes of food infection and poisoning, however, are germs and their poisonous products—the toxins. The illness they cause usually takes the form of gastroenteritis, with symptoms of diarrhea, vomiting, and cramping pain in the abdomen. Depending on the particular germ present, the illness may take other specific forms such as paratyphoid fever, dysentery, scarlet fever, septic sore throat, or botulism; trench mouth and infantile paralysis may also be conveyed by food. Even influenza, the common cold, and tuberculosis have been attributed to infected food or crockery, but if infection by such means occurs it unusual, for they are usually contracted from breathing heavily infected air.

To grow germs in a laboratory it is necessary to put them into a

culture medium containing suitable food and to keep them at a warm temperature. Meat broth, milk and eggs are good substances to use as media. Under favorable conditions, the organisms multiply every half-hour, so that in 12 hours a single germ may produce 15½ millions and half-an-hour later 33 millions. If, however, the temperature is too cold, the germs stop multiplying, although they do not necessarily die.

It is thus possible to state the conditions necessary for an outbreak of bacterial food poisoning. First, the food must be contaminated with the germ. Second, the food must be of a type which will allow the germs to grow. Third, the food must be incubated (i.e., kept suitably warm) so as to promote growth of the germs.

To deal with the last two points first: It has already been mentioned that prepared meats, milk, and eggs are suitable media for bacterial growth; and their products such as sausage meat, croquettes, pies, pastries filled with artificial or real cream, custard-filled bakery products and ice cream are most often responsible for food poisoning. Two examples will demonstrate the part incubation plays in food poisoning. A woman, living alone, opened a tin of good soup and inadvertently a little pus from a wound on her thumb got into the soup. She consumed half the tin without ill effect and left the remainder in her warm kitchen for seven days. She then warmed it up and consumed it. Within three hours she was violently ill with diarrhea and vomiting, and within twenty-four hours she was dead. A week's incubation had made the soup lethal. In another case, some ice cream mixture was allowed to stand for twelve to twenty hours before being frozen. When consumed later it caused food poisoning, whereas some similar material not left standing about caused no trouble.

Mode of Contamination
How is the food contaminated in
the first place? Usually the germs
are deposited on it by human beings,
by animals such as mice and rats,

or by insects such as flies. rare for food to be contaminated before it reaches the caterer, because of the fairly rigid inspection of food (particularly meat) by the public health authorities. There was, however, a little relaxation during the war and examples of such infection occurred. Dried eggs sometimes contain salmonella germs, while pork products may be infected with the trichinosis parasite capable of causing illness. (It is advised that all pork products should be thoroughly cooked to destroy these organisms.) Recently there was an outbreak due to unwholesome rabbit. A large consignment of rabbits included one animal which was diseased before it was caught and which escaped detection during inspection. All the rabbits were cut up, and parts of the diseased carcass got into three pies while two dozen other pies were not contaminated. Those who ate of the tainted pies were affected (not seriously) while all the others escaped. In tracing the cause of this outbreak the difficulty was to determine why so few groups were affected although all had apparently eaten the same food.

Mice and rats sometimes suffer from an infection which is capable of causing poisoning in humans if their droppings or urine contaminate food. Flies also act as conveyors of infection, and such fatal diseases as infantile diarrhea, dysentery, and poliomyelitis have been attributed to such carriage. The germs causing food poisoning, however, are often derived directly from human excreta.

In the past, before excrement was dealt with in a sanitary manner, it was deposited on the ground thus contaminating wells and other water supplies and causing such diseases as typhoid fever. Today, the proper disposal of sewage and the provision of a pure water supply are guaranteed in most countries by the public health During the war, in authorities. Great Britain, there was the fear that damage to sewers and watermains by enemy action might result in contamination of the water and, to counteract this danger, antiseptic

substances were added to the water. The unsatisfactory water supply in some countries explains their inhabitants' preference for the safer bottled waters, but water-borne diseases are rare today.

Excreta may also be carried to food by the hands of those preparing it. If a kitchen worker is infected he may easily and unknowingly carry a few germs on his hands after using the sanitary convenience. He may have recently suffered from a diarrheal disorder or may be a carrier (i.e., a healthy person who carries the germs his intestines without himself suffering any ill effects). If the germs he carries are passed on to others they may cause serious illness, and every kitchen worker affected with diarrhea should, therefore, report such illness to his doctor and employer. The most important rule of personal hygiene for kitchen staff is to wash the hands with soap and water after using a sanitary convenience, and it is advisable to post a notice in the lavatory instructing the staff to do so. The law now requires facilities to be provided in catering establishments for such washing, and hot water, soap and towels must be available. Indeed, it is sound hygiene for all to wash their hands before preparing or sitting down to a meal.

Food may also be contaminated by germs from the skin, the nose and throat. Septic sores and boils on the hands and arms contain bacteria capable of causing disease, as the above-mentioned case of the woman with the tin of soup illustrates. Staff suffering from such skin ailments must not, therefore, handle food until the condition has cleared up. The nose, particularly after a cold, is the home of many germs. It is surprising how frequently people's fingers stray to their noses, and germs capable of causing illness are also expelled during coughing and sneez-The mouth and nose must, therefore, be guarded with a handkerchief at such times, special care being taken not to cough or sneeze over food or to touch one's nose while handling food.

CLEANLINESS OF PREMISES, EQUIP-MENT AND UTENSILS

So much for personal hygiene; now let us discuss the cleanliness of the premises. General cleanliness of the floors, walls, ceilings, and doors is only possible if they are kept in proper repair. If food is properly stored and cleanliness observed the prospect of infestation by mice and rats is diminished. A warning should be given about the use of commercial rat and mouse poison; there is danger that the germ causing disease in the rodent may be conveyed to food and cause food poisoning. A kitchen worker who squeezed a mop out after using it on a floor laid with this bait infected her own hands and thus the food she was preparing.

Much greater care is also needed in the disposal of refuse and waste, because it will do much to eliminate the fly population. Garbage cans should be properly covered with water-tight lids, emptied regularly and frequently, and cleaned, preferably with a steam jet. Garbage collectors should avoid bruising cans by rough treatment and thus damaging the rims so that the lids no longer fit. There is a great advantage in grading refuse into plain refuse and ashes; waste food; bones and waste fats; and paper and tins. In the future, DDT will help us to destroy flies, but it will not eliminate the cause of their presence.

Lastly, something should be said about the cleansing of equipment and utensils. Crockery, particularly when dirty and cracked, has been found to harbor germs capable of causing disease. Soap and water liberally supplied is a highly efficient disinfectant, but how frequently is washing-up performed in a most perfunctory manner, particularly during rush perriods? The washing water should be warm (110-120°F.), contain an adequate amount of soap, and changed as frequently as is necessary. washing, rinsing in really hot water (170°F, for two minutes or boiling water for half a minute) will remove the cleansing material.

STUDENT NURSES PAGE

Bacterial Pericarditis

GERALDINE ALLBEE

Affiliating Student Nurse at Children's Memorial Hospital, Montreal, from Rutland, Vermont

ONLY THIRTY-SIX hours before admission to the hospital, Richard wakened during the night and complained of earache. He was unable to sleep and felt warm to touch. During the day the earache diminished, but he began to have slight difficulty in swallowing, and his voice became hoarse. Later he complained of abdominal pain, had considerable difficulty in swallowing, and vomited twice. He was seen by his doctor who advised admission to hospital.

At the time of admission the fever was 102°F. A tentative diagnosis of pneumonia was made, and treatment with penicillin started immediately. Physical examination showed, according to the interne's report, a child who was breathing with rapid, grunting respirations, with lungs which seemed normal to percussion and auscultation. heart was not enlarged and there was no murmur. Examination of the abdomen showed marked rigidity and spasm which seemed to be generalized with some increased tenderness in the upper quadrants. Thus the possibility of appendicitis was intro-duced. The throat was red and the uvula swollen. The surgeon was called in consultation and he advised waiting and watching. During the night the doctors felt that the abdominal signs pointed to thoracic rather than abdominal disease, and a rapidly enlarging heart suggested acute

pericarditis. Finally the heart specialist, with the aid of x-ray, E.C.G. and signs which developed rapidly in the child, was able to confirm the diagnosis of acute bacterial pericarditis with purulent effusion.

Bacterial pericarditis is not common in infancy and early childhood, but when it does occur at an early age it most frequently results from the extension of an infection in the respiratory tract. This commonly produces a suppurative type of pericarditis which causes a high mortality rate. There may be no local signs to focus attention on the pericardium.

As soon as diagnosis was definitely established, the medical treatment consisted of the following:

Aspiration of the pericardium daily; penicillin, 10,000 units every three hours; streptomycin, 50,000 units every three hours; intravenous therapy; oxygen tent for cyanosis.

During the time I nursed Richard there were three special problems that existed. He was irritable, he had little or no appetite, and he seemed unable to lie passively in bed while I was attending to his physical needs. It took patience to ignore the irritability and to do things slowly without feeling strained. He needed some diversion, but the physical condition dictated something simple which required no concentration, strain or excitement. He enjoyed

NOVEMBLE 1947

small dolls, picture books, listening to stories and, best of all, he liked a small plastic doll carriage. When I removed his toys for the night I was careful to place the carriage where he could reach it saying, "Richard, I will put it here where you can reach it when you wake up." He often "fussed" upon awakening, asking for his father and mother. He was interested in stories and I found reading to him the best way of putting him to sleep. He was too ill to hold attention for long and would drop off to sleep fairly soon. I would try to find something different every half-hour or so if he were awake.

The child's appetite was poor but the management of the food problem was not too difficult. I served his food in very small amounts, cutting his bread in small pieces, and he soon began to improve. He usually wakened at 9 p.m., and as he was fond of chocolate milk there was a drink ready for him. He needed a considerable amount of fluid to combat the infection, the fever, and the loss of fluid through perspiration. He was good about taking fluids.

The general care which Richard required was similar to that of any acutely ill and febrile patient, except that it was difficult to save him physical exertion. He could not

understand what I meant when I asked him to lie still and I would lift and turn him. Before I could move him he would have struggled by himself and he never did learn to lie passively in bed. Flannelette sheets were used because of the excessive perspiration and they required frequent changing. He was supported up in bed with pillows. He was tired after bathing so that sponge baths for fever were not given. The doctors depended upon chemotherapy and aspiration of the purulent material from the pericardium to control the infection. He was very co-operative during the intramuscular injections and the pericardial In the first instance I was careful to explain to him and to tell him the truth. Eight days after admission chemotherapy was discontinued, and on the twelfth day the pericardium seemed to be free of purulent material. Richard had been healthy before this illness, he came from a good home, and his parents were capable of convalescent care under their doctor's direction. Consequently, he was discharged home sixteen days after admission, having made a remarkable recovery. He was an interesting patient and I learned that understanding the child and caring for him as an individual is an important part of pediatric nursing.

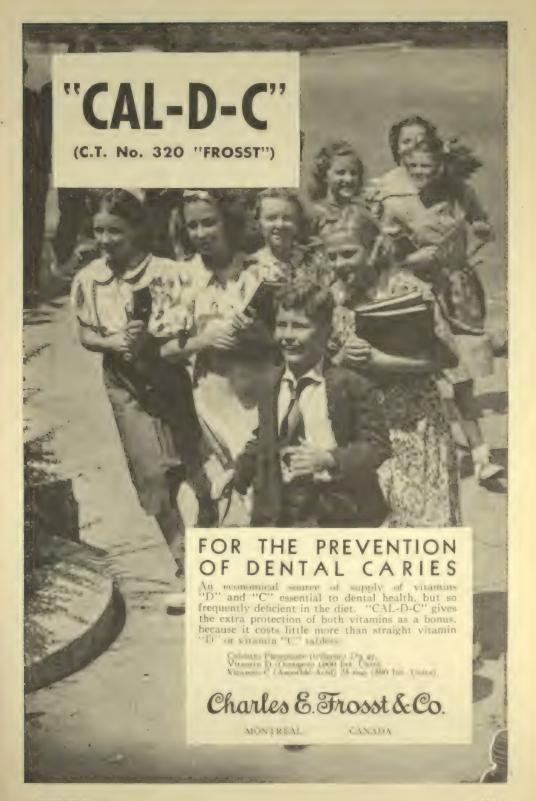
What is a Profession?

The following was presented by Professor R. Freeman Butts, Teachers College, Columbia University, as part of the panel discussion on "Employer-Faculty Responsibility in Developing Nursing Personnel on the Job and in the University," at the conference and reunion, Alumnae of the Nursing Education Division, Teachers College, Columbia University, May 20, 1947:

As a proposal for your thinking and discussion, I suggest that the following are seven characteristics that a group of people must have in order to reach full status as a profession. I suggest them as a check list by

which to measure whether the nursing profession, the teaching profession, or any other profession may have the right to call itself a profession:

1. The group must be organized. No group of people is a profession unless it is organized in such a way as to enhance the consciousness of the worth and integrity of the group as a means of rendering a service in some aspect of the everyday life of the people. Thus, a profession has a basically collective character through which the individuals heighten their powers and facilities for rendering that service.



- 2. The group must rest its services upon the mastery of a common body of knowledge and skill. This mastery depends upon spending considerable time in supervised study, learning, and practice before the member is permitted full standing in the profession. The attainment of the requisite knowledge and skill is in large measure an intellectual task requiring university-level study. The mastery of scientific, philosophic, and theoretical knowledge is a requisite that characterizes one group a profession, the lack of which characterizes another group as a less well-developed occupation.
- 3. The group must have a large share in determining the qualifications which must be possessed by those who would enter upon the profession. Since an extended period of study is necessary as a preparation before and after entering the profession, the standards of admission must be worked out by the profession and by the public working co-operatively. A profession should not be given complete autonomy in this regard nor should a public or private agency be given full authority for determining such qualifications.
- 4. The group must develop a code of ethics governing the relations of its members to the public and to each other. This must be generous and devoted to the welfare of all concerned and not limited to what will merely help the practitioner.
- 5. The group must be officially recognized by the government of the people whom the profession serves. Whatever licensing or approval is necessary for practising the profession must be officially a matter of recognition by some agency that is responsible to the public.
- 6. The group must achieve an economic and social status that is sufficient to attract and hold persons with high intellectual and personal qualities. Nursing and teaching have

- a peculiarly difficult task in this respect, because, of all the professions, they most commonly rest upon salaries paid by an employer rather than upon fees paid by a client or patient. This makes the kind of professional organization that is developed for these groups of very great importance as a means of achieving the status and rewards worthy of a profession. The public will pay adequate salaries when it is convinced of the worth of the service. This "convincing" is difficult and often a political task.
- 7. The group must have effective working relationships with other groups in society. This means that a profession may and oftentimes must work not only with other professional groups but also with labor and other private and public organizations as a means of mobilizing efforts for shaping public policy with respect to the services it represents.

Above all, there must be a recognition of the general social welfare involved in the practice of a profession. The public and general welfare must take precedence over the individual and private interest. When any occupational group links its service functions with a liberal understanding and appreciation of the social and cultural context in which those services are rendered, that group moves in the direction of a profession.

A profession, in other words, has basically an educational function. One who "professes" is one who has something to teach to others. A profession has the educational function to lift the quality of life in a community. I sum up this function in the words, "education of the public." All professions must be engaged in the education of the public, not simply in providing the opportunity for the professional worker to earn a livelihood, or to make money, or to sell his services.

-New Jersey State Nurses' Association Bulletin

Co-operative Refresher Course

For the last few years, at every meeting of the Cornwall Chapter the question has been asked, "What shall we do to broaden our educational interests?" And the answer usually given was—"A modified refresher course, perhaps?" So, last spring, the nebulous refresher course evolved into reality.

With the rapid developments in all fields of medicine as a result of accelerated scientific research which goes hand-in-hand with each succeeding war—one indirect outcome of war that we can be thankful for—one finds it difficult to keep abreast of these many achievements. We are so busy nursing that

→ Adventure . . .

History . . .

Service . . .

THREE CENTURIES OF CANADIAN NURSING

Ву

John Murray Gibbon, LL.D., and Mary Mathewson, R.N.

Publication date NOVEMBER 15

Probable Price \$1.50

9

528 pages 50 pages of illustrations The history of Canadian nursing is a fascinating story of brave adventure, bitter suffering and sacrifice, and finally of great achievement; and the publication of this book marks the culmination of more than fifteen years of work in compiling records, searching for, and checking all available data.

Today the title of Canadian Nurse is honoured all over Europe as a result of the services she has given in two world wars, and on this continent Canadian training is recognized as a hall-mark of quality.

Every Canadian nurse, and indeed all Canadians, will find in this beautifully illustrated and well-written book a new cause for pride in our country.

THE MACMILLAN COMPANY OF CANADA LTD.

70 BOND STREET

TORONTO 2, ONT.

NOV | MBFR, 1947

there is little time for study; yet, without continued study we cannot be good nurses! So, in an effort to circumvent this vicious circle in our own little sphere, we got down to the serious business of planning a series of lectures and demonstrations.

The committee was composed of the local R.N.A.O. convener of Nurse Education, Sister Margaret Mary, Sister Mooney, and Miss Evelyn Paul, convener of Education for the Cornwall Nursing Registry.

Our first plans were somewhat elaborate; we thought of having lectures twice a week for a month. The idea was voiced at a registry meeting last November at which Miss Madalene Baker was present. Miss Baker kindly suggested that we "tone down" a little on our initial venture, that is, that we decrease both the number of lectures and the time spacing. We are grateful to Miss Baker for this suggestion as it subsequently proved more effective.

After much changing and arranging, and with the invaluable advice and assistance of Dr. Lorne A. Caldwell, who is on the Education Committee of the registry, the program was mailed to all nurses in the district, both graduate and student, as well as to some alumnae members working not too far distant—Montreal, Potsdam, Massena, etc. Embellished with appropriate sketches depicting the theme of various lectures, it read as follows:

YOU are cordially invited to attend the refresher course sponsored by the Cornwall Chapter of the R.N.A.O. and the Nursing Registry, to be held at the Cornwall General Hospital, Nurses Residence, with the following program:

First evening: Mr. William Mitchell: "First

aid with particular reference to artificial respiration." Rev. Sr. Margaret Mary: "Wangensteen suction apparatus." Lecture and demonstration.

Second evening: Dr. A. E. R. MacPhee: "Anesthesia." Dr. L. A. Caldwell: "Some pertinent points of interest to nurses regarding fractures, from Sir Reginald Watson-Jones's lectures in Toronto, January, 1947."

Third evening: Miss Margaret McKenzie, Dept. of Public Health: "The nurse's responsibility in venereal diseases." Miss Sybil Everitt, Victorian Order of Nurses: "Delivery in the home." Lecture and demonstration.

Presentation of prizes by Dr. Roy Mc-Gregor Nichol for student nurses' posters. Poster topics as follows: Intermediate students: Intravenous Therapy; senior students: Progress of Nursing.

The posters, prepared and displayed by the student nurses of the two Cornwall hospitals, were exceptionally well done and showed a wealth of careful planning and painstaking execution: The senior students of the Cornwall General won the prize for their poster depicting the progress of nursing and the Hotel Dieu intermediate students won the prize for their poster on intravenous therapy. In presenting the prizes, Dr. Nichol congratulated the student nurses on their artistic work.

Some sixty nurses registered for this course and everyone was most enthusiastic, both about the educational achievement and the pleasure of the social aspect of the event. The net proceeds, on the basis of three dollar registration fees, was seventy dollars. It has been banked to be used in arranging for the next refresher course. We hope to make it an annual event.

Industrial Nursing Refresher

Miss Caroline Barrett, chairman, English Chapter, District 11, A.N.P.Q., introduced the speakers at the first two lectures of the series arranged for nurses in industry by the Public Health Section, A.N.P.Q.

On May 14, Dr. Graham Ross, chief medical director, National Breweries, opened the series, speaking on "Industrial Nursing and Personnel Relationships." The object of the medical department in industry is to keep the whole working force in a state of health and efficiency, Dr. Ross told the group. Thus, preventive measures are an important part of industrial medicine. The nurse in industry has a very real opportunity for health teaching in her frequent contacts with the same people over a long period. She may be somewhat restricted in an industrial medical

THE INTERNATIONAL COUNCIL OF NURSES

EXECUTIVE SECRETARY WANTED

Applications are invited from members of the Canadian Nurses' Association. Position open to nurse, of at least 35 years of age, who has had broad general education, good professional qualifications and experience, preferably with experience in a secretarial capacity. Knowledge of several languages highly desirable.

Salary: £800 per annum with annual increment of £50 to maximum of £1,100.

Thirty days' holidays per annum with additional period of one month's leave at end of each three years of service.

Subsistence allowance while travelling for I.C.N., sick leave and superannuation.

For further information or in application term to:

Miss Gerda Hôjer, President, I.C.N. Ostermalmsgatan, 33, Stockholm, Sweden.

centre because "production" is the important thing in industry; she, too, must show a "profit."

Dr. Ross felt that the medical department was in a splendid position in industry, being between management and the employee, and should maintain this advantage, avoiding any inclination to "take sides," and thus keep the confidence of both.

Dr. Fred Smith, Dean of Medicine, McGill University, spoke on "Newer Drugs and Recent Developments in Therapy" at the second session on May 21.

Dr. Smith dealt only with the antibiotics—the sulphas, penicillin, and streptomycin.

It was interesting to learn that the group of diseases for which penicillin is effective are scarcely affected by treatment with streptomycin, and vice versa. Unfortunately, neither drug affects the many virus and fungus diseases. The lecture was much appreciated and thoroughly covered this topic of current interest.

Miss Elinor Barnstead, supervisor of Case Work, Family Welfare Association, spoke on the subject "Community Resources" on June 4. Miss Barnstead was introduced by Miss Electa MacLennan assistant director. McGill School for Graduate Nurses.

Miss Barnstead outlined the many problems which might be on a worker's mind, and affect his health and his job. These would mainly come under two headings: Home problems, including illness of employee or a member of his family; behavior problems of children, particularly when both parents are working; domestic trouble between husband and wife; pregnancy; unmarried mothers; debts or poor management. Social problems would include: housing shortage; hospital bed shortage; dearth of domestic help; and lack of adequate day nurseries.

Miss Barnstead urged the nurses to use the services offered by the agencies. The nurse referring a case can be of immense help by properly preparing the patient, explaining that a welfare agency is more than a charitable institution.

The final lecture of the series was on June 11. Miss Mary Mathewson, superintendent of marses at the Memtreal Control Happing, was chairman and introduced the speaker, Miss Frances Harris, consultant on industrial nursing with the Department of National Health and Welfare.

Miss Harris summed up the previous lec-

Readily Digestible MILK MODIFIERS for INFANT FEEDING

Crown Brand and Lily White Corn Syrups are well known to the medical profession as a thoroughly safe and satisfactory carbohydrate for use as a milk modifier in the bottle feeding of infants.

These pure corn syrups can be readily digested and do not irritate the delicate intestinal tract of the infant.



"CROWN BRAND" and "LILY WHITE" CORN SYRUPS

Manufactured by THE CANADA STARCH COMPANY Limited
MONTREAL AND TORONTO

tures regarding the position of the nurse in industry. She pointed out some of the opportunities for helping the employee himself, his family, and the community in general. The nurse in industry, knowing the patient, his family and background, must act as interpreter, clarifying the situation for the doctor, since in the large and complicated social set-

up of today the doctor cannot possibly know these things as the old-time general practitioner did.

There was some discussion afterwards of particular problems the nurses have met. The lectures were well attended and enthusiastically received, and the committee feel well satisfied with the venture.

Book Reviews

A History of Nursing, by Gladys Sellew, Ph.D., R.N. and C. J. Nuesse, Ph.D. 444 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1946. Illustrated. Price \$4.00.

Reviewed by Aileen Riordan of Montreal.

This book is a valuable addition to the many references available for teachers and students on History of Nursing. It is a convenient size, attractively bound, well illustrated and is printed in a clear type on semigloss paper. The table of contents, because of the generous number of sub-headings for each of the twenty-one chapters, facilitates

its use as a reference. Some additional teaching and learning aids are the "Questions for Study and Discussion," and the many references—historical, cultural, and social—listed under "Suggestions for Reading" at the end of each chapter.

In the preface the authors challenge nurses, in the light of a true understanding of their professional duties, to strive for an insight into contemporary problems, past and present, and to active participation in the solution of future ones. In the book they adhere to the central thesis—the inextricable interweaving of nursing service with all other branches of human culture. Historically

• VOLUME 43 NUMBER 12 MONTREAL DECEMBER 1947

CANADIAN NIBSE



Merry
Christmas
and
Happy

New Dear





a 'wellcome' solution for a seasonal problem

The problem of relieving the nasal congestion associated with colds, sinusitis, and rhinitis can be effectively solved by application of 'Wellcome' brand Ephedrine Isotonic Solution (Aqueous).

It contains 1 per cent of Ephedrine in a modified Locke's Solution; a combination which offers four distinct advantages of comfort and benefit to patients:

- It has an immediate and prolonged effect of mucosal shrinkage.
- Unlike oily preparations and those containing various antiseptics, it does not impede ciliary function.
- 3. It is non-irritating.
- 4. Its application is not followed by after-congestion.

'Wellcome' brand

Ephedrine Isotonic Solution

(Aqueous)

Available in bottles of 1 fl. oz. (with a dropper) and 16 fl. oz.



BURROUGHS WELLCOME & CO. (The Wellcome Foundation Ltd.) Montreal



A New Name in the Pharmaceutical Field WINTHROP-STEARNS INC.

Winthrop-Stearns Inc. has acquired the business of Winthrop Chemical Company, Inc., organized in 1919, and the products of Frederick Stearns & Company, organized in 1855.

Winthrop-Stearns Inc. will utilize extensive manufacturing facilities at Windsor, Ontario.

Winthrop-Stearns Inc. will carry on the honored tradition of both Winthrop and Stearns in its relationships with the physicians and pharmacists of Canada, in its scholarship and fellowship policies, and in its laboratory and clinical research dedicated to medical progress.

WINTHROP-STEARNS INC.

1019 ELLIOTT STREET, W.

WINDSOR, ONTARIO

DECEMBER, 1947

Reader's Guide

Many of you have suggested that it would be very helpful if the biographical data regarding our authors were condensed into a brief line or two, and appended on the article page itself. .That change will be instituted with the January, 1948, issue, This page will still be included to draw your attention to specially featured articles but its function and material will be altered somewhat, henceforth. We want to share with you here some of the nice things people say about the Journal, some of the problems they raise, some of the questions they ask. For instance, this paragraph from a letter we received in September gave us quite a lift:

"I stayed in bed Sunday morning intending to glance over the *Journal*, then start in on a new book. I did not put the *Journal* down till it was time to get ready for lunch. I am all agog now to attend the next I.C.N. Congress in Sweden in 1949. I suppose it is too early to have any estimate of cost?"

We are trying to get some information on probable costs of the trip to Sweden. Freighters seem the cheapest means of transportation so far, and even they are around five hundred dollars return. We will keep you posted but you had better start saving now!

You will enjoy reading **Dr. Athol Gordon's** consideration of "The Nurse in a Changing Age." Dr. Gordon is a veteran physician in Winnipeg who saw service in both world wars. He enthralled his audience at the annual banquet of the Manitoba Association of Registered Nurses when he delivered this address as guest speaker.

The Committee on Instruction of the Association of Nurses of the Province of Quebec has followed up the plea made in the article "Conflicting Ideas in Textbooks." (The Canadian Nurse, Sept. 1945). After consulting various authorities, they have produced under the name of Clara Aitkenhead, who until recently was an instructor at Homoeopathic Hospital, Montreal, a very workable and effective guide which might well be written into the service manuals in all hospitals in Canada. This group is to be congratulated on the valuable contribution they have made to the problems of isolation techniques.

Mary L. Shepherd, who is superintendent

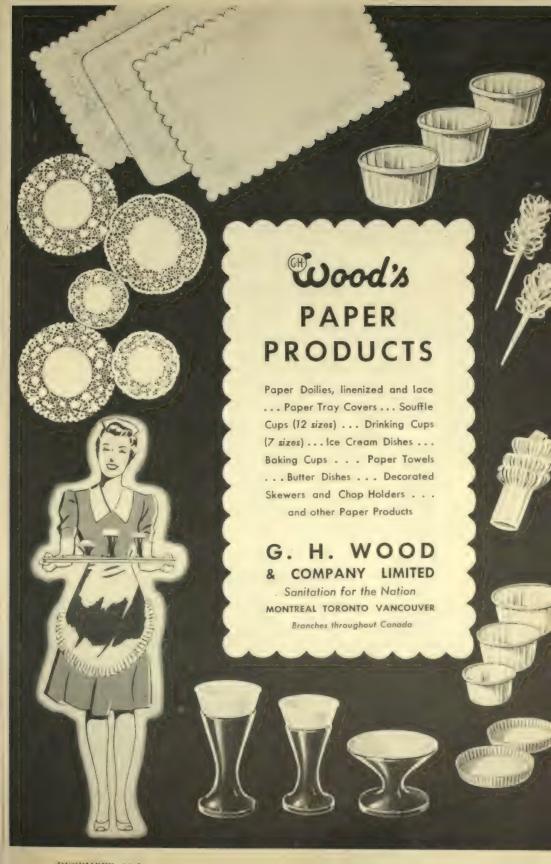
of nurses of the Winnipeg Municipal Hospitals, has prepared a very detailed outline of the procedures that are carried out in her hospital for the admission of communicable disease patients, their routine care in "units," the technique of their discharge, etc. The program functions smoothly in the well-equipped hospital in Winnipeg which sets a workable pattern. Used in conjunction with Miss Aitkenhead's summary these techniques provide a sound basis for a modern communicable disease service.

What do student nurses do when they are off duty? **Sheila Ogilvie**, herself a fairly recent graduate from the Vancouver General Hospital, makes many constructive suggestions regarding recreational opportunities. Miss Ogilvie is engaged in public health nursing in Vancouver.

Nora Tillson had a "bee in her bonnet" about the problem of enuresis and it did not stop worrying her until she had developed the plan which she has described for us. Since this is a common problem met by nurses everywhere, we'hope that many of you will put her suggestions into practice and thus bring happiness to scores of youngsters. Miss Tillson is a senior member of the City of Windsor Board of Health.

Helen E. Penhale is the very able director of the nursing education courses at the University of Alberta. She delved into some of the reasons for the shortage of nurses in Alberta and has uncovered some rather amazing information. For example, while there were a total of 1,860 nurses actively registered in the A.A.R.N., there were 2,496 inactive members. While 139 reciprocal registrants joined the A.A.R.N. from other provinces or countries, 213 migrated to other parts of the world. This shifting of nurse population is occurring everywhere and helps to complicate the supply of nurses problem.

Phyllis (Reeve) Blackall was educational director with the Metropolitan Health Committee, Vancouver, prior, to her recent marriage in England. We would all agree that the careful evaluation of a nurse's capabilities is not to be undertaken light-heartedly. Mrs. Blackall has outlined the method they devel-



oped to make the task less burdensome and more efficient.

The last issue of Volume 43! As in other years, the detailed index to all of the material that has been published in this volume will be available for ready reference. Our total number of pages did not quite equal the large figure which we reached last year but then there was no special convention issue. Even if our page total is less, our subscriber total has grown considerably. At the end of 1946 we had a grand total of 8,511 paid subscribers on our lists. This year? We will not hazard

a guess at what the year-end total will be. On November 1, when this copy had to go to the printers, the lists revealed that some of the provinces had taken an enormous leap since the last figures were published. Take a good look at Saskatchewan for a real thrill. In our last published report they had a total of 641. Take a look at them now! Here are the figures: Alberta, 823; British Columbia, 1,403; Manitoba, 602; New Brunswick, 585; Nova Scotia, 609; Ontario, 3,414; Prince Edward Island, 145; Quebec, 1,021; Saskatchewan, 1,203; foreign subscribers, 616 — a grand total of 10,421.

Interest is Keen

The Canadian Nurse poster competition, which was announced in the October, 1947, issue, is arousing considerable interest in all parts of Canada. Inter-class competitions in many schools of nursing have already been reported. We have heard of one school where the director of nursing has offered a prize of two pairs of nylon stockings as the award for the best poster from her school. In another, the alumnae association is offering prizes for the student efforts. Write and tell us what special incentive your association is offering.

Remember the purpose of the competition—to provide a collection of "sales-appeal" posters for the *Journal*. Somebody in each province is going to win a fifteen dollar prize

and it might just as well be you. In addition, there is that further award of another fifteen dollars for the best of the nine posters.

It has been suggested that, with Easter coming early next year (Easter Sunday will be on March 28), it might be well to terminate the competition on March 1, 1948, so that the awards could be made in time for the recipients to do some Easter shopping. That seems a very sound idea so please note that the closing date is advanced one month. Send your entries in early. Be sure that they are carefully wrapped to prevent bending, crumpling of corners, etc. Send them to The Canadian Nurse, Suite 522, 1538 Sherbrooke St. West, Montreal 25, P.Q.

Better get busy!

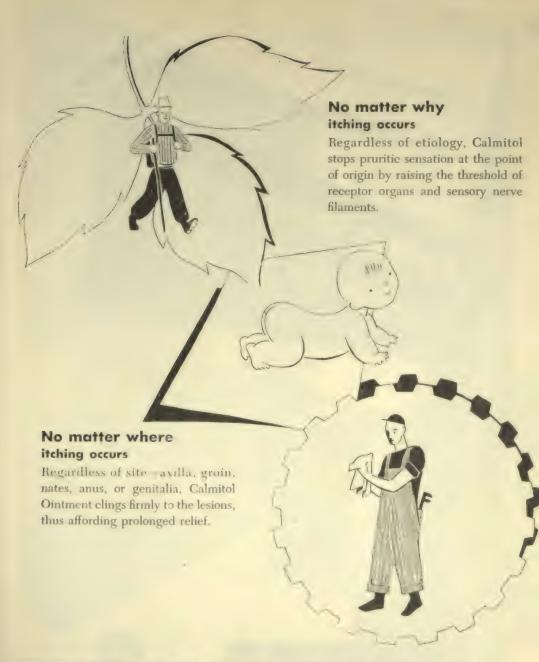
The Vermin-Killer

Many interesting and unusual ideas may be learned from the perusal of "The Vermin-Killer: Being a complete and necessary Family-Book," published in London in the 18th Century. This little book, in the collection of the History of Medicine Division, tells the reader such things as how to kill fleas, how to buy a horse, the best cure for colic, and rules to "judge the weather." The following are a few choice items:

"Recipe for the Bite of a mad Dog, taken out of Cathorp Church in Lincolnshire, in which it was solemnly recorded for the perpetual Memory of the Thing, that the whole Town almost being bitten, not one Person miscarried, but was cured, who took this Method—

"Take the Leaves of Rue pick'd from the Stalks, and bruised, six ounces; Garlick pick'd from the Stalks and bruised, Venice-Treacle or Mithridate, and Scrapings of Pewter, of each four ounces; boil all these over a slow Fire in two Quarts of Ale till one Pint is consumed; keep it in a Bottle close stopped, and give of it nine Spoonfuls warm to the Person seven Mornings successively, and six to a Dog . . ; apply some of the Ingredients to the Part bitten. . .

"Fox to take: Anoint the Soals of your Shoes with Swine's Fat a little broiled, and coming from the Wood, drop here and there a Piece of roasted Swine's Liver dipt in Honey, drawing after you a dead Cat, and he'll follow you, so that you may shoot him."



CALMITOL

The Leeming Miles Go Lid.

1 NOTRE DAME ST. W., MONTREAL I, CANADA

No matter how much or how often

Regardless of extent or frequency of use Calmitol is safe. It does not contain harmfu phenol or cocaine. Its active antipruritic in gredients, camphorated chloral and hyoscy mine oleate, will not be absorbed systemically

DECEMBER, 1947

an important new addition A liver preparation with

AYERST LIVER EXTRACT with FOLIC ACID No. 351

The excellent results obtained by the use of folic acid in pernicious and other macrocytic anaemias have suggested that the combined administration of folic acid and liver extract is more effective than either alone. Each dry powder capsule of Ayerst Liver Extract with Folic Acid contains the antipernicious anaemia principle obtained from 2/3 ounce of fresh liver in addition to 0.5 mg. of folic acid. Supplied in bottles of 100 capsules.

Other Ayerst Liver Extract Preparations

INJECTABLE . LIQUID . CAPSULES . POWDER



AYERST, MCKENNA & HARRISON LIMITED Biological and Pharmaceutical Chemists CANADA MONTREAL 448



Canadian Tampax Corporation Ltd.,

Brampton, Ontario.

Send hterature and professional samples send educational material for . . . students

NAME

Please print

ADDRESS

or external irritations...does not expose
the flux to odorous decompositions... and cannot
cause noticeable bulkiness. Its small size makes TAMPAX
inconspicuous to carry and easy to store and dispose of.

Samples of the three absorbencies (Regular, Super and Junior) for individual requirements gladly forwarded on request.

REFERENCES. 1. West J Surg. Obst. & Gvn., \$1:150, 1943. 2. Am. J. Obst. & Gyn. 46. 259. 1943. 3. Clin. Med. & Surg., 46. 327, 1939. 4. Am. J., Obst. & Gyn., 48:510, 1944. 5. J.A.M.A., 128. 490, 1945.

Radio

A
PROFITABLE
INVESTMENT
FOR
HOSPITALS

Write for this descriptive booklet on the MARCONI "Central Unit" system.







PILLOW TYPE LOUDSPEAKER Placed beneath the pillow, programmes are heard only by patient.



TABLE OR WALL TYPE LOUDSPEAKER
For use in private rooms with easily accessible controls,

The installation of a Marconi "Central Unit" system offers many advantages to the modern hospital. The radio provides diversion for patients so that they require less attention from a busy hospital staff. This diversion also helps to speed the recovery and discharge of patients — another benefit to overcrowded hospitals.

The Marconi system quickly pays for itself. Patients are more than willing to pay a small rental charge, thus providing a steady source of income to the hospital.

CANADIAN MARCONI COMPANY

Established 1903

MARCONI BUILDING

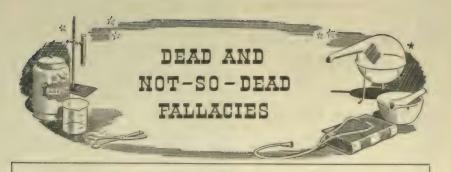
MONTREAL

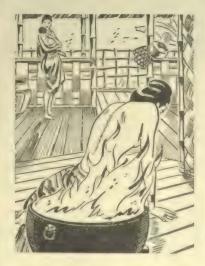
Vancouver Winnipeg Toronto Halifax

lifax St. John's, Nfld.

MARCONI - The Greatest Name in Radio

914 Vol. 43, No. 12





A great many people today be-

In Siam years ago, after the birth of a first child, the mother alternately exposed her back and abdomen to a fire for 30 days.

It was believed that this torture appeased the gods and prevented the most direful consequences to both mother and child. A great many people today believe that if there is rust on the outside of a can, the food inside is contaminated.

This is a fallacy. Unless the rust has pierced the metal, the contents of the can are perfectly safe and nutritious.



AMERICAN CAN COMPANY

KENTVILLE • MONTREAL • HAMILTON • TORONTO • WINNIPEG • VANCOUVER

CANNED FOOD IS GRAND FOOD

DECEMBER, 1947 915

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING MONTREAL

COURSES FOR GRADUATE NURSES

- 1. A four-month course in Obstetrical Nursing.
- 2. A two-month course in Gynecological Nursing.

For further information apply to:
Miss Caroline Barrett, R.N., Supervisor, Women's Pavilion, Royal
Victoria Hospital, Montreal 2,
P. Q.

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

THE MOUNTAIN SANATORIUM HAMILTON, ONTARIO

THREE-MONTH POST-GRADU-ATE COURSE IN THE IMMUNO-LOGY, PREVENTION, AND TREATMENT OF TUBERCULOSIS

is offered to Registered Nurses. This course is especially valuable to those contemplating public health, industrial, or tuberculosis nursing.

Salary: 1st and 2nd months—\$100; 3rd month — \$110 — plus full maintenance.

For further information apply to:

Miss Ellen Ewart, Supt. of Nurses, Mountain Sanatorium, Hamilton, Ontario

McGill University School for Graduate Nurses

COURSES OFFERED

- Degree Courses -

Two-year courses leading to the degree, Bachelor of Nursing. Opportunity is provided for specialization in field of choice.

- One-Year Certificate Courses-

Teaching and Supervision in Schools of Nursing.

Administration in Schools of Nursing. Supervision in Psychiatric Nursing. Supervision in Obstetrical Nursing. Public Health Nursing.

Administration and Supervision in Public Health Nursing.

For information apply to School for Graduate Nurses 1266 Pine Ave. W. McGILL UNIVERSITY, MONTREAL 25

TORONTO HOSPITAL

Weston, Ontario

THREE-MONTH POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary—\$104.50 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.



Save laundering with Johnson's DRAX*

... it makes fabrics resist dirt and soil!

Have you heard the new way to keep fabrics fresh and clean-looking longer . . . cut down on laundering costs? It's Johnson's DRAX and it's like nothing you've ever heard of before.

Actually, DRAX is an invisible wax rinse that guards each thread of the fabric from dirt and soil. They stay sparkling-white longer . . . are easier to wash . . . easier to iron! This means

less frequent trips to the laundry, and easier laundering. You save money both ways!

DRAX is made by the makers of Johnson's Wax and has been used with amazing success in many Canadian hospitals, hotels, and restaurants. Wonderful for uniforms and tablecloths, tool It will pay you to find out about DRAX today!

DRAX is made by the makers of Johnson's Wax

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA



Vol. 43, No. 12

The

CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE

NUMBER TWELVE

MONTREAL, DECEMBER, 1947

ensembles to the content of the cont

"Where We Gone"

When we hear any grossly ungrammatical phrases uttered we are inclined to be heartily amused. That was our first reaction to the supposed remark of one of those heroes of the oft-told tales. "If we hadn't came where we gone, we wouldn't have saw what we seen or did what we done." The truth behind that silly arrangement of words struck us as we began to think back over nursing progress during 1947 and we were amazed to find how much has developed.

It is customary in any up-andcoming business to do some stocktaking at the end of the year. Let us then, remember back over the past twelve months—what have we "saw," what have we "did" along the road? Where have we "came" this year? What would we have missed if we hadn't "gone" this road?

Dozens of important and interesting things have occurred. There was no national nursing convention in Canada this year but over three hundred of our colleagues attended the International Council of Nurses Congress in Atlantic City last May. This opportunity to renew acquaintances and to make new international contacts was one of the very bright spots in this year's activity.

The Canadian Nurses' Association and, through it, every member of our provincial nursing associations gained new stature this year with the federal government's seal of approval on our incorporation act. We have talked about and worked for that somewhat nebulous entity, the nursing profession, for a great many years without it having any valid legal status. Now it has. A worthy landmark this for the years to come! To Eileen Flanagan as chairman of the Committee on Legislation and to Gertrude Hall, our indefatigable general secretary, go special commendation for their untiring zeal.

A new development this year is the Demonstration School which is scheduled to open shortly. This is not planned primarily to alleviate the current shortage of nurses by produc-



ing qualified graduates more quickly. That will happen, of course, but that result is incidental to the main problem of determining just how long is required, under controlled conditions of training, to thoroughly prepare a young woman to assume her duties and responsibilities as a graduate nurse. What does it actually cost to train a nurse? No one can foresee what the results will be—that we will learn four years hence. In the interval, we shall watch the demonstration with interest.

One of the unsolved problems along our route this year has been the recurring difficulty of too many jobs and not enough nurses to fill them. The common cry of "Where are all the nurses" cannot be answered easily. It is an involved problem. In 1946, 3,598 students were graduated from our schools of nursing. The number estimated to have graduated this year is even higher-3,773 nurses. Where have over seven thousand nurses disappeared or have they? Hundreds of them have married and a large proportion of these are still working. Some have gone to the United States to work. Most of them are right here in Canada endeavoring to meet the ever-increasing demands for nursing service.

We could go on reviewing the

myriad accomplishments of individual nurses, of the chapters, the provincial associations, but Christmas is almost here. All this month, carols will be practised in preparation for the chill hours of dawn on Christmas Day when choruses of nurses' voices will be heard through the corridors of our hospitals. The photographer caught the sparkle of happiness on the candlelit faces of the students and graduates pictured on our cover. They are the carollers at the General and Marine Hospital, Collingwood, Ont. "Peace on earth! Good will toward men!" If only everyone meant those words as they sing them, and lived them out in their everyday contacts—what a different world it would be!

"Where have we came?" A long road—sometimes difficult, more times happy. As the year draws to a close, we, in the office of *The Canadian Nurse*, re-echo the words of Charles Dickens' character Doctor Marigold,

as he said:

My best of wishes for your merry Christmases and your happy New Years, your long lives and your true prosperities. Worth twenty pound good if they are delivered as I send them. Remember! Here's a final prescription added, "To be taken for life."

Merry Christmas and a Very Prosperous New Year!

Christmas Day in a Jap Prison

Editor's Note: This story was sent to us several months ago and we have been saving it to bring to you in this our Christmas issue. Its tale of suffering and distress, then the curious privileges which Christmas brought to these lads, imprisoned in Rangoon,

THERE WILL BE many happy reunions this Christmas. For me it will be something more than a reunion or a holiday with those I love. It does not seem very long ago that my family were mourning my death and, unknown to them, I was mourning the presents an inspiring story. At the time it was written, one year ago, the author, who is anonymous, was completing a course in law at the University of Saskatchewan. We are grateful to him for permitting us to share this story with you.

fact that after four years of happy Air Force life I had fallen into the hands of the Japanese. I was shot down over an enemy aerodrome on the 11th of December and the weeks that followed are not pretty to tell about. But on the 25th, I lived a day filled with the

strangest happiness I have ever known.

The story of my capture and the days that followed is much the same as those you have all read about. was beaten, threatened, cursed and kicked till I began to wonder if it were worth the effort to try to live. The thoughts of a quick and painless death became a hope—sometimes a I was finally taken from Northern Burma to Rangoon. There I was thrown into a cell, eight feet by eight feet, and started five months of incarceration which was to be a nightmare from which I could not escape, and an education that could not be duplicated in any of our Occidental universities.

When the Allied Air Force first started to bomb the Japanese homeland, their Imperial Army broadcast to the world that they would treat any allied airmen as war criminals, if they were captured. When I was shot down I learned what this meant. At Rangoon I was thrown into solitary confinement. I was given quarter rations-that is, one-quarter the ration they gave their own troops. It was not enough to keep a man alive. That was one of their ways of showing us our mistake in being cruel, civilian-killing airmen. We, in the cells, were not allowed to talk or smoke. For those of us suffering from wounds, there was no medical treatment to ease our pain. The guards walked slowly by our cells all day long, carrying clubs the size and shape of a pickhandle. If we did not bow low to show our respect each time they passed we were given a 15-minute "lesson" with the club so we would not be so careless the next time. Life was truly hell and, since we were not able to contact the outside world, there seemed to be very little to hope for. Then, as I sav. Christmas Day, 1944, arrived.

Whispered rumors that something extraordinary would happen on Christmas day had passed from cell to cell the week before, and we could only hope it would be something to make that one day a little different. Rumors were rampant—"they are going to give us an extra ration of rice...

maybe we will get a piece of meat . . . I think we will get a cigarette." Our quarter ration consisted of a cruelly small paddle of rice per meal—no meat, no vegetables, not even a hint of something sweet, so it was not hard to hope that the Japs would realize that Christmas was "The Day" of the Christian year and would increase our rations a little. On Christmas Eve I crawled into my corner and lay on the hard boards, burning with a feeling of expectancy I had not had since I had reached maturity.

The next morning the bars of the main door were slammed back as they had been slammed back every day before. The guard marched past to check the cells. His club and the expression on his face were unchanged —both were cruel. The clacking of wooden sandals on concrete floor broadcast the arrival of the Chinese prisoners with our breakfast. I tried to stick my head through a 6-inch space between the bars, but I couldn't see them. I stood there like a little beggar child, hoping against hope that something would come to make this day just a little different. The guard walked slowly by my cell. I bowed. The Chinese were carrying their buckets of rice to my cell. The rice fell into my tin pan, a little more than usual, and I breathed a "thank you." Then the Christmas present that I will remember for the rest of my days was placed on my plate. An old Chinaman clicked up to my cell carrying a tray full of cookies, and placed one of them on my rice. A real cookie! I just stared at that small lump of sweetened rice and my heart cried thanks to the God that had made these degenerate devils do this act of kindness on this special day. As I stood silently by my door, entranced by the beauty of that little brown cookie, another Chinaman carried a pail down the corridor. He stopped and put my second present on my plate. My eyes popped. It was the foreleg of a cow! There was no meat on that huge 2½ foot of bone of course, but my bearer had served me 12-course Indian dinners in Calcutta that I did not appreciate

as much. A panful of steaming rice, a cookie and a bone. Before I lifted my pan into the cell, I breathed a very sincere "thank you." We had not

been forgotten.

I sat on the boards which were my bed, pressed my head against the cold concrete wall, and laughed. My pans were empty. The last sweet granule of rice was gone. The bone, so very bare of flesh when it came, was now chewed and sucked and gnawed till it was something less than a bone. I glanced at the empty pan on the floor, and my thoughts went back to dreamlike days of old when, after eating an 8-course turkey dinner, I had sat back from the table and looked at the stacks of still uneaten food. The creamy mashed potatoes, the thin, delicate slices of white meat, the small round cut-glass dishes of cranberry sauce, a large bowl of spiced dressing, the many kinds of cake. I reminisced there in my cell till I felt the old glow of satisfaction steal over me. I closed my eyes and heard again the sweet and moving carols we had sung around the Christmas tree. In my imagination, I untied red ribbon and striped paper, spattered with colorful stickers from mysterious parcels. I saw my father's humorous grin as he opened yet another gaudy tie. I heard the frosty, crunching footsteps in the snow as my schoolmates arrived to see what I had received and to show me their watches and socks, books and skates. I heard my mother singing softly and humbly, "Silent Night, Holy Night, all is calm, all is bright."

"Tuskeh!" I tried to get to my feet too quickly as the Jap order for "attention" rapped through the building. An officer had returned with the guards, and my heart was palpitating madly as one of the guards walked slowly down the corridor, opening cells as he went. I stood stiffly at attention, hating the moment when the order would come to step through the door. I could only think of mass execution. Nothing to parallel this had ever happened before. The order came. I took a deep breath and stepped through the barred door. I looked down the corridor and saw fifty other bearded animals emerge and stand in wondering silence. The Jap officer swaggered to the middle of the corridor and in a stentorian voice and a school-boy accent said: "To all the prisoners in this block, today is Christian Christmas. My commanding officer has said today you will smoke. Tonight when roll-call has been taken, you will sing your Christian songs. This will be for one day only. You will not talk.

Nippon Masters are good."

His words resounded through my mind as he walked out. The guards started to distribute Burmese cheroots to every man, but we stood there as though we were struck dumb. received five of the green-leaved cigars. I gripped them tightly and looked across the corridor at a bearded American flier standing there. was literally a grin from ear to ear. A smoke! A real, honest-to-goodness smoke! The guard walked back and took the five of us to an empty cell at the end of the prison. He lit a match and we dragged heavily on the green tobacco. I inhaled the first drag as I used to inhale a cigarette. I thought I would never stop coughing, and the guard laughed. "You smoke Okayka?" "Hai mistersmoko goodka!" He seemed to be in a good mood and as I looked at the American I laughed like a child with a new toy. The American's countenance was composed of a magnificent black silky beard, two large coalblack eyes, and a grin that would shame a Cheshire cat. "Johnnie, can vou believe it?"

We each blew a slow, lazy smoke ring and they met and folded into one another. We sat down and spent the next ten minutes grinning and blowing rings at one another. If ever a tobacco company wanted a testimonial, here was the place to get it. That ten minutes was enough to reacquaint us with the glorious feeling of freedom that had once been a happy reality. I went back to my cell feeling indescribably happy and thankful and, as much as I hated to admit it, I felt there might be the slightest chance that a little drop of kindness

might be found in a Jap's soul. I spent the rest of the day smoking those four cheroots and acquiring a murderous headache.

The evening pan of rice was miserably small, but I didn't care. I could hardly repress my feelings as I waited for that moment when the guard would leave us alone for the night. The moment, when after days of sitting silent, of cautious whispering down the dark alley, of winks and thumbs-up signs, we would sing those wonderful Christmas carols.

The sergeant of the guard took an interminably long time checking the cells that night. He finished, walked slowly down the corridor. The bars crashed home and a moment of dead silence followed. Then a clear, deep voice sounded "Our Father Who Art in Heaven, Hallowed be Thy Name, Thy Kingdom Come. . . . " I closed my eyes tightly and leaned my head against the bars. I whispered there silently but sincerely, "Thy Will be Done on Earth as it is in Heaven." The prayer finished, a tense quiet reigned till an American drawl said, "Wal, feels if a'hm gonna get home afore my wife comes after me. We're gonna have to start this thing pretty quick—how's about singing, the Herald Angels Sing'—eh?"

There was a Dutch boy in a cell on the top floor. He had escaped from Holland in 1940, joined the R.A.F., and had come to India to fly Liberators. He had a deep, rolling voice, still heavy with his native accent. He started to sing now. . Unfaltering, deep and clear, that great bass voice rang through the ancient, darkened prison. At the very other end, on the bottom floor, another voice joined, then another, and another. Then we all joined in. The concrete walls shot our echoes back as we sang. We sang as though it might be the last time we would be able to sing. We sang and shouted those pent-up emotions into that dark and empty corridor—"Hark the Herald Angels Sing, Glory to the

Newborn King." "Dutch, sing us a solo, come on, Dutch, atta-boy, Dutch." Dutch's low deep voice then reached us all. "Tonight I will sing you a song in my native tongue that I sang when I was young—it seemed beautiful then; I think it is beautiful now."

I think I shall never be thrilled by music as I was when, in those few minutes, Dutch sang, in the words of his homeland, "Silent Night, Holy Night." His voice, clear and deep as a cathedral bell, rang through the prison and out into the Burmese A hundred-odd miserable night. creatures crouched low against the barred doors of their cells and, without exception, there were soft, warm tears in a hundred-odd pairs of burning eyes. As the last echo of that beautiful melody grew fainter and fainter. I could hear the heavy breathing from cells next to mine, then a

quiet voice said, "Thank you, Dutch." We sang every song we could think of that night. We coursed through the carols and the songs we had learned at school. We listened with humorous appreciation as a Hillbilly from Arkansas sang a song of the hills and the haunts he had walked as a boy. Dutch sang "The Volga Boatman" in Russian; an English lad sang "Come, Landlord, Fill the Flowing Bowl Until it Doth Run Over" · in a high, sweet tenor voice that one would expect to hear hallooing the hounds on an English hunt. When we ran out of old songs, we sang them over again and again. Hours later we lay down to sleep. Life had changed for me that night. A mass process of revisualization was going on in my mind and if ever again I walked the paths of Freedom, I would retain that sense of values. I would need so little, so very little to keep me happy.

This year I hear of shortages at home. Sugar, butter, meat—"How will we manage?" I laugh—I am going

to have a happy Christmis.

New Zealand's infant mortality rate during 1946, 25.35 deaths per 1,000 live births

is the basest exer recorded by a moder-country.

The Nurse in a Changing Age

ATHOL GORDON, M.D.

THE WORLD TODAY presents a fearful

and wondrous picture!

Convulsed by War, Famine and Pestilence. Striving for a goal of Peace and Happiness. Hindered by diplomatic protocol, political ex-

pediency, and unworthy motivation.

There is nevertheless a motif of a different spirit to be heard above and through the cacophonous music. It is the motif of Noble Desire . . . faint and lost from time to time, but nonetheless discernible to the listening ear. Everyone who hears it longs for its continuance; and only those who can interpret it as the motif of Service have heard the true notes. I suggest to you that the great profession of nurses the world over is magnificently equipped to bring that motif to the forefront of the New World Symphony.

We are going to violate a precedent by not conjuring up the spirit of that great lady with the lamp, nor that of her famous literary ancestor, that equally great lady with her umbrella, and her gin bottle, Sairey Gamp. These two, though ever-present in the wings, are *not* to walk the stage of our imaginations. Requiescant in pace.

TAKING STOCK

The nursing profession presently finds itself in a splendidly precarious position in this changing age. I say "splendidly" for its opportunity is as never before in its history . . . and I say "precarious" for if it fails now it may go down to deserved oblivion. So perhaps it would be well to take stock of the component material, the nurse; for the profession to succeed must know itself. Burns has well said, "Oh wad some power the giftie gie us to see oursels as others see us.

The public sees you . . . and the public is a hydra-headed monster only describable in terms of very mixed metaphors. It is a wraith-like thing that no one can touch . . . a stern judge . . . a fickle friend . . . an implacable foe . . . a thing that is all soul and no soul, at once . . . a golden apple or a harp, to the politician . . . a veering weathercock to the unbiased observer . . . and, in the long run, a very long run indeed, it is an accurate assessor of worth.

What does it see as it looks at the nurse today? With the coldest impartiality it sees her as: (a) skilled and qualified . . . accepts her tacitly; (b) unskilled though qualified . . . damns her! (c) as a "practical nurse, unqualified but skilled or unskilled.

The poor man sees her: As a possible solution to his inconvenient problem of illness . . . as an added cost . . . as a much needed aid, worthy or unworthy of his financial denials . . . as an alternative to going to hospital ... as a salvation in the internal economy of his deranged home . . . as a terrible waste of money spent on her employment.

The hospital and the matron see her: As grist for the school mill with potentialities to be discovered, and, if possible, applied . . . as a compilation of its administrative problems of housing and replacement . . . as a completely necessary component of its machine, which leaves it at the moment of achieving its maximum efficiency . . . as giving service, good or bad, from her probationer days to her graduation . . . a justification or otherwise of its power of personnel selection . . . or, as the matron would say, "Good material, run o' the mill, or hopeless."

The laboratory sees her: As a washer of test-tubes and slides . . . as a good aide, capable of routine procedures . . . as potential technician material, liable or not to depart at

the call of Cupid.

The government sees her: As duly qualified under the laws of the province or the Dominion . . . as a commodity to be placed strategically in cities, towns, rural and unorganized

districts in the front line of an advancing electorate. This electorate it admits should have the necessary nursing. So it sees her as a sort of chameleon, adaptable to industry, the laboratory, public health service, and capable of filling the role of medical, surgical, obstetrical, pediatric nurse at a moment's notice.

The industrialist, viewing his payments to the Workmen's Compensation Board, seeing his staff in danger (in spite of installation of safety devices) . . . viewing these things as problems or factors in his production . . . sees the nurse as a bulwark versus all the difficulties that follow in the wake of accidents, major or minor, and the subsequent complications. He perhaps does not always realize how much he needs high-grade material in the factory nurse.

The general practitioner (the obsolescent dodo of the medical profession) sees her: In the home, as a vindication of his advice that she be installed . . . or as an example of his bad judgment if she fails. In the hospital, where she is not his direct responsibility, as an aid or a horrible hindrance to the patient's recovery . . . as an aid or a hindrance to his own peace of mind about the case in hand. In the school or factory as a wise guide and counsellor, not abrogating more to herself than the situation demands . . . or as a meddlesome fool.

The patient sees her according to the nature of himself, herself, and the nature of the disease; and this view has many facets in her praise or damnation. It might be said, in general, that he sees her as a blonde . . . brunette . . . red-headed . . . mousecolored . . . ministering angel as she sets his pulses bounding with (shall we say) sympathetic appreciation. Or as a "ditto" fiend who stands over him waving a pendant rectal catheter and prepares him for a horror before which the Johnstown flood pales into insignificance. Or as a calm quiet personality, who, when most needed. appeared . . . did things . . . brought order out of chaos . . . stepped into the family economy and restored its normal state . . . who rolled up her

sleeves and did tasks quite beneath the dignity of a "trained nurse" . . . and who, from the layman's point of view, earned her pay many times over . . . but didn't get on much with that sweater she was knitting . . . and knew full well the value of few words and many deeds.

She sees herself: Ah! My friends! If I were able to speak with profound knowledge here I could do miracles. I could read the riddle of the sphinx. Even the mighty Shakespeare, who portrayed human nature more closely than anyone before or after him, was confused by the magnificent enigma of women and he fell into a morass of frustration crying:

For men have marble, women waxen minds; And therefore are they formed as marble will; The weak impressed, th'impression of strange kinds

Is formed in them by force, by fraud, or skill; Then call them not the authors of their ill No more than wax should be accounted evil Wherein is stamped the semblance of a devil.

The *idealist* sees herself fulfilling a desire for *service*... achieving a goal of accomplishment... winning prizes and praises; and succeeding in the support of herself or family... vindicating her existence in a society slow to value women except as an adornment to the nobility of man.

The realist sees herself armed for security should marriage fail to materialize, or break down after the event. (We might note in passing that the realist and the idealist may change places suddenly or gradually under the impact of circumstances.)

The behaviorist sees her destiny beyond the pale of nursing, and sees the possibility of contacts which will quickly lead her out from nursing into a new life, attended by a glittering host of Doctor Kildares.

The student sees herself in a field of specialism where she avoids the menial aspects of her profession, passion ately embracing the outer garments of science or industry.

The permutations and combinations of even this small series becomes immense with the advance of age, the impact of life, and the consequent change in the sense of relative values.

Small wonder then, if, surrounded by all of life's pressures, she occasionally loses her sense of values to the bugaboo of frustration, bearing in its arms the pile of unpaid bills, and sneering at her as she faintly points to the prospective income from long overdue accounts, which she realizes are nothing but a black loss.

THE PRESENT POSITION

The history of progress is heavily lined with the story of group organization for gain: and one finds the nursing profession an organization which stands ready to carry out the prime need of today—revised, redistributed, and advanced training. Surely the present system is almost an anachronism. To expect the student nurse to jump from the classroom to ward and back again . . . to face a night of study, after a long day of mind and foot-wearing routine . . . to go from ward to examination . . . is to say the least unreasonable.

None of us feel that theory is entirely dissociable from practice; but a redistribution of study is long overdue in the training school; and the nursing profession stands for this very thing. Going to any government for financial assistance, excepting during the war years, has met with an exhalation of political "hot and cold," which is not exactly the breath of life. On analysis it turns out to be the breath of political expediency.

The thing now needed is a clear statement of the position of the nursing profession to be placed before the public in the persons of the industrialists, the public health services. the medical profession, the financiers. the farmers, the general public. The brief for each must contain arguments applicable to and comprehensible by each group approached. It should contain a request for action by such groups directed to the government. If the demand is loud enough to be Vox Populi, it will be construed by any government as Vox Dei: Let this be so, and doubt not, but Success Will fashion the event in better shape

Much Ado IV-I:235
Among the public (and even within

Than I can lay it down in likelihood.

the ranks of the nursing profession itself) are voices which say "Why all this accent on specialized training?" What of the cost? Nurses have trained before without a special degree. Why not continue? Then out comes a whole battalion of cliches... "Better to learn to rub a back than to write a vitamin C essay"... "If she can't get into a kitchen and cook what use is she"... and so on.

Why are these silly arguments so effective? The fault lies in the failure of those who have brought antipathy upon the whole profession. Alas, it is true that there is no task, which, well done would have brought credit, that has not been bungled at various times. . . "The evil that men (and nurses) do lives after them. The good is oft interred with their bones."

We have said nothing about the heartless exploitation of the nurse in some homes, of insults, of unkindness, of injustice. These things are written off against the kindnesses, the gifts, the friendships, the gratitude that have been the experience of most of you. Each must just keep her own mental ledger and balance it each year if possible; and, if not, she must carry forward the debit or credit balance for or against humanity. There is a value in this procedure which engenders a constructive healthy spirit of self-criticism which can only tend to good for the honest assessor.

THE ROLE OF ASSOCIATIONS

An association which merely appeals for fees is, of course an unworthy thing. One without membership fees is a ruined one. It behooves the nursing profession to gird up figurative loins, and give something very tangible to their members.

Look at the Winnipeg Medical Society which, apart from all its other activities, keeps its members briefed on the advances in all branches of medicine by the programs of its monthly meetings. Many a tip is given and taken. Many a question is subjected to all grades of critical examination, and many a man is better informed on leaving these

meetings . . . better armed to carry the war against disease and death

into the enemy's camp.

Nursing associations could embark upon an ambitious program of nursing education which would be most valuable. The leaders in every field of nursing could each present her special subject, giving it complete coverage and sharing her knowledge with you all. Your minds would travel from Aklavik to Atikokan . . . from the Queen Charlotte Islands to St. Pierre and Miquelon . . . from Hong Kong to Hamburg . . . from the industrial plant to the hospital . . . from the laboratory to the home . . . from the teepee of the Indian to the encumbered palaces of the rich . . . and you would gain in wisdom and sympathy, the two precious attributes of which the poor old world stands in such sore need today. Besides, it would be great fun. Rolls and coffee are not very expensive, even with the ceilings off. Attendance will grow as you feed the personnel. Those who are watching the scales can skip the bread and butter . . . but I don't imagine you will actually save much there.

All this is in preparation for the day which will surely come, when the voice of the nursing associations is more potent than that of Sinatra upon the governmental ear . . . I can almost hear them scream and swoon. Although that day is not here yet, there is no excuse for association idleness.

The laws of nature are as unchanging as the famed laws of the Medes and Persians. A leg or an arm kept long enough in a cast becomes feebler and feebler, smaller and smaller; and finally it ceases to function as a limb forever. This is the grim statement of the law of atrophy through disuse. It applies to a person, a community, or a nation with equal force. An atrophic association will reap the inevitable award of functional oblivion . . . unready to take advantage of benefits which might accrue in the evolutionary process of governmental realiza-

So much for collective activity. What of the individual? Here is a rich field for further discussion. The individual member must make known her problems and her wishes. These must be given due attention . . . be given open discussion; and the questioner must be advised of the night for problem solution . . . she should come prepared to speak her piece however small . . . but she may be no speaker! In this event one must be found for her, and be briefed by her for the meeting. She must work for the association when asked . . . work hard, and work cheerfully . . . even to washing up the coffee cups.

THE EXECUTIVE COMMITTEE

And the executive, what of it? There seems to be not the slightest danger of atrophy through inactivity here, but every executive should beware of it. Its members are not ibso facto, superior officers, but executive servants, whose every pronouncement must be weighed in the balance of advisability and expediency, shorn of personality and tested in the crucible of experience, or the retort of The executive is experiment. . . charged with the heavy and difficult duty of satisfying disgruntled cliques, and the continual stimulation of interest. Well might it groan with Hamlet's wicked uncle: "Oh heavy burden.'

The nominating committee must be widely representative and not the result of a clique selection; and its nominating slate must have a goodly list of nominees for each office. At its deliberations let it beware of the baleful effect of those railroading "I move the nominations closed" . . . after one nomination has been made. When electing an officer let each member review the candidate under the headings of experience . . . personality . . . enthusiasm . . . ability . . . rejecting her if all these are not found. These attributes are hard, indeed, to find in one and the same person; but they are absolute prerequisites in an elected executive officer. Personal feelings are bound to be present but they must be sternly repressed by each of you as you prepare to ballot . . . for are you not

ballotting for the successful operation

of your association?

The fact of evolution in the great scheme of things is too well established to be gainsaid; and the principle of adaptation to environment is amply demonstrated. When through millions of years the fish slowly took to the land to become a lizard it only very slowly shed its gills, took its lungs within its body case, and developed the typical pentadactyl limbs; but it never went backward.

Nursing associations might well follow, to some extent at least, this evolutionary form of development. It is better far than the revolutionary form, and a failure to make a sharp and immediate advance should not be viewed with antipathy borne of frustration, but rather as an indication that its own internal development had not completed its adaptation. The subsequent evolutionary stage will follow as the night, the day.

Nothing will stop it.

In spite of the trend toward specialization, there are always to be found certain nurses who are intrigued by the idea of taking care of someone. Their whole aim is the doing of this grand job . . . call the instinct what you will—maternal instinct, sublimation of a frustration, a complex of some kind or other . . . but when one of these is given a good brain, a deft pair of hands, a good physique (especially arches and back) there appears a creature beloved of suffering

people, and a veritable gift to the world, one for whom there might well have been another beatitude: "Blessed is the nurse, for she shall be called God's shield against pain."

They tell us that Canada stands on the verge of a great future. So indeed she does. That future depends on many factors ponderable and im-

ponderable.

Canada maple land: Land of great mountains Lake land and river land: land twixt the seas. And we may well pray:

Grant us Lord, hearts that are large as our heritage

Spirits as free as the breeze.

But while a nation grows today, it does so under the terrible shadow of the four sinister horsemen of the Apocalypse—War . . . Famine . . . Pestilence . . . and Death. Arrayed against this awful force stands medicine and its glittering handmaiden, science. Their shields gleam with the polish of achievement and are sadly dented with the grim marks of failure; but their bearers stand undaunted and unafraid.

But who is this who, standing beside them, wields the weapons they have forged, and casts a protecting arm around the wounded and sick? It is the nurse . . . the plain girl . . . not always with scholarships, but with good training, indomitable courage, and an unquenchable desire to serve. She must be the child of St. George and St. Joan, this nurse of the future . . . this child of God.

Leukemia

Leukemia is considered to be a malignant disease, and as such its death rate may properly be included with that from cancer. For the period 1941-45, the death rate from leukemia was about 4 per cent of that from cancer. Furthermore, among white males, the mortality from leukemia is higher than that for cancer of any site except the digestive tract, the prostate, and the lungs; in early childhood, it exceeds the death rate from all forms of cancer combined.

The death rate from leukemia is higher among males than among females at every age period; the widest difference is in late childhood and adolescence, when the rate for males is about twice that for females. Persons afflicted with the disease, irrespective of sex or age, live only a relatively short time; to date, recovery has not been reported in any authenticated case. However, the newer methods of treatment, now being tried, give some promise.

- M.L.I.C. Statistical Bulletin

More than four hundred Canadian Army officers and men were killed or wounded during air attacks on Great Britain in World War II, the army's historical section has reported.

Communicable Disease Techniques

MARY L. SHEPHERD

THE Winnipeg Municipal Hospitals are responsible for the care of all cases of acute communicable disease requiring hospitalization. This care is provided by student nurses affiliated from the general hospitals of the city, working under the supervision of a graduate staff. Definite techniques or procedures are required to provide uniformity of care, to prevent cross-infection, to safeguard / indefinite cases, to protect those working around the patient, and to avoid the spread of disease to well persons in the community.

The actual accommodation provided for patient care must be so planned as to ensure plenty of space so that nurses may enter the ward in safety without contaminating their uniforms while putting on the gown. Space is required also so that separate technique may be carried out for each patient in a given area.

THE NECESSARY SET-UP

In our set-up, we limit the various communicable diseases to a given unit, each complete in itself. Our practice is to divide each room into separate units, with each unit numbered for convenience. The unit consists of a bed, bedside table, chair, and the surrounding wall. thing contained within that unit must be washable and soap and water are used freely to keep it clean. We provide each patient with towels, face cloth, soap, soap dish, comb, and tooth-brush. These articles are kept within the immediate area of the patient. All other articles are removed. Basins, bed-pans, etc., are boiled for ten minutes after each use. Papers, letters, and books are burned. After the attendant has handled anything which is contaminated, she must wash her hands and arms thoroughly with soap and running water for two minutes before going to other units or to clean areas.

Gown technique is very important. The nurse's gown must cover her entire uniform. Our gowns are made with elbow-length sleeves, ties at the neck, open all the way down the back, with ties that fasten around the waist. There are lockers or stands on which to hang the gowns. These are numbered to correspond with the patients' units. They are placed on the opposite side of the room from the beds so that the patients cannot reach them, The actual technique we follow is explained in detail below. An ample supply of doctors' and nurses' gowns should always be available.

Sinks with running water, preferably those operated by foot pedals, should be conveniently located. We have sand-glasses at each sink to

"time" the scrub.

Sterilizers form an important part of the equipment of a communicable diseases hospital. We have large, deep. monometal sterilizers with steam attachments in each kitchen, in which we boil the dishes and trays. Similar sterilizers are in each service room for boiling the basins, etc. sterilizers are installed also.

The hopper into which bed-pans are emptied is always considered contaminated and thus a source of infection. The nurse must, therefore, scrub after emptying the pan and before returning to any patient's unit. The soiled linen chute is also considered contaminated and the same technique is used as following the emptying of a bed-pan.

All floors are considered contam-

inated.

CLEAN AREA

Certain areas are kept "clean" or uncontaminated at all times. These areas include: (a) the nurse's desk; (b) all linen and supply cupboards; (c) all medicine cupboards; (d) the entire service room excepting the linen chute, hopper, and floor; (e)

DECEMBER, 1947 020 the entire kitchen, with the exception of the floor; (f) all units not occupied by patients. These have been thoroughly cleaned following the discharge from hospital of the last occupant. If any clean unit should accidentally become contaminated, it is immediately washed with soap and water.

All windows, window-sills, screens, and sinks are kept as clean as possible. The wards are aired thoroughly at all times.

AMBULANCE TECHNIQUE

The entire ambulance is clean and uncontaminated when it leaves the hospital to pick up a patient. The driver dons a white coat before he enters the home. If the patient is ambulatory, he may walk to the ambulance. However, if a child is carried out from the home, he is wrapped in an ambulance blanket or placed on a stretcher. The patient is taken to the admitting-room where a nurse receives him.

The ambulance driver immediately removes the white coat and places it in the proper receptacle, together with the contaminated blankets, pillow-cases, etc., used for that case. The entire interior of the ambulance is washed with soap and water, then aired. Fresh blankets and linens are put on the stretcher to be in readiness for the next call.

ADMITTING-ROOM TECHNIQUE

Excepting for the floor, the entire admitting-room is considered "clean" when the patient enters. The desk is always kept clean. In it will be found: the admitting book; cards and information forms; valuables envelopes; clothes lists, to be completed in triplicate; culture tubes; tongue depressors; antitoxins; sterile syringes. Completely equipped trays for giving antitoxin or a lumbar puncture are at hand.

Care is taken to prevent the patient or any visitors from touching the desk or anything on it. The chairs for parents or others who may have accompanied the patient are so placed as to be away from the desk and also from the stretcher on which the patient is lying.

The stretcher is covered with a large sheet, adjusted so that it over-hangs both sides of the stretcher. These ends will be used to cover the patient when he is being wheeled to the ward. A large blue light is placed directly over the stretcher to permit the examining doctor to see the throat, rash, etc., without difficulty.

In a clean cupboard there is a supply of gowns for the protection of the doctor and nurse. Nearby is a container for contaminated gowns.

Procedure: With the patient on the stretcher, the relatives on the specially. placed chairs, the doctor proceeds to take the history before he becomes contaminated. The nurse prepares contaminated. the clothes tags, valuables envelopes, etc. She has a hospital night-gown and sponge blanket in readiness before she dons her gown. Since the personal clothes of patients are never taken to the ward, the nurse undresses him, places the clothes on hangers and tags them. A contaminated clothes room is nearby. The clothing remains there until removed by an attendant. The room where they have been hung is sprayed with Izol solution.

The valuables are checked with the patient, then placed in an open valuables bag, the outside of which is not contaminated. Money and papers will later be autoclaved. Other valuables, such as jewelry, which cannot be autoclaved safely, are washed with soap and water and placed in a clean bag. All valuables bags are labelled and locked up in the business office.

Meanwhile, the doctor, having completed the history, puts on a gown and, with the assistance of the nurse, takes the throat culture and makes a complete examination of the patient. It is essential that a correct diagnosis be made here, if possible, so that the patient may be taken to the proper ward. Indefinite, atypical cases are always kept in separate rooms, away from all other patients, until the diagnosis is ascertained. This completed, the doctor removes the gown, scrubs for two minutes, then enters the

signs, symptoms, and diagnosis on the history.

As soon as the relatives leave, the nurse washes the chairs thoroughly with soap and water. No other part of the admitting-room has been contaminated. She then removes her gown, scrubs for two minutes, and folds the over-hanging portion of the stretcher sheet over the patient. She handles only the outside, the clean area of the sheet, and so avoids any danger of contamination between the admitting-room and the patient's unit. If by any mischance the stretcher should become contaminated during this process, it is washed immediately with soap and water. A clean sheet is placed on it in readiness for the next patient.

GOWN TECHNIQUE

Gowns are worn for all bedside care. The gown is hung up with the clean side inside with the opening facing the nurse, It is hung out of the reach of the patient.

The following procedure is used in

putting on the gown:

Reach through the opening at the back of gown to clean area inside, and lift gown from hook. Slip gown on, handling only the inside, still keeping hands clean until strings at back of neck are tied.

Grasp the two edges of the gown at back, fold together, and overlap slightly to hold gown together. Then, with hands now contaminated, cross ties at back of waist, and tie securely in front. Wear until entire unit care is completed.

To remove the gown, these steps are just reversed, as follows:

Undo ties at waist, and let them drop. With hands still contaminated, lift one corner of gown (about area of right hip) from outside and tuck under opposite arm. This is to keep the gown from falling forward, as the nurse bends over the sink to scrub, thus contaminating sink.

Turn contaminated sand-glass and scrub hands and arms with soap and running water for two minutes, using brush on nails only.

Dry hands and arms thoroughly with small towels provided (kept in basket above sink) and discard towel into basket below sink. With clean hand, reach under to the clean area of gown being held under left arm, and let the gown down. Unfasten ties at neck of gown. Then, handling inside of sleeves, bring them down over hands.

With both hands still inside armholes of gown, place the two clean sides of the gown flat together, secure the open areas at back of gown securely together, then, catching both armholes (and with hands now contaminated from outside of gown) hang on hook.

Take basins, linen, etc., from unit to be sterilized. Scrub hands and arms for two minutes.

Care must always be taken to avoid contaminating face, hair, or uniform. Gowns are changed frequently. We do not use caps or masks in the care of these diseases. Hair is worn securely pinned or in hair-nets.

THE PATIENTS' TRAYS

The meals are served to patients on individual trays from the steamtable which is brought to the ward. Second servings may be had if desired and then the food remaining is returned to the main kitchen at once. Before any contaminated trays are brought back to the ward kitchen, the table is covered with newspapers to keep it clean. The tap is turned on and left running to (a) rinse all dishes before boiling them and (b) to avoid contaminating the taps.

As the contaminated trays are brought out, they are placed on the newspaper, the trays stripped, the dishes rinsed, then piled with the trays in the sterilizer. The newspapers are folded up and placed in the waste can.

After the hands have been scrubbed up, the sterilizer is filled with water above the level of the trays and dishes. The steam is turned on, and when the water begins boiling it is left to boil for ten minutes. The dishes are removed from the sterilizer, washed with soap and water, and reset on the trays.

PREVENTING SPREAD OF INFECTION

As important as the nursing care given to the patients is the protection of the nurse herself. Every effort is made through careful observance of technique to prevent those giving care

from becoming infected. Additional practices include: recent immunizations; maintaining good physical well-being through adequate diet, fresh air, and sunshine; early recognition and isolation of the ill person, etc. The nurse is warned not to take any chances with the technique even though she may have had the disease already. She *might* develop it again and she would certainly be a hazard to those who were scrupulously carrying out every detail of the technique.

The patients are instructed to remain in their own units. This is especially difficult with small children who are tempted to hop out of bed to rescue their playthings from the floor. Patients are always reminded to cover the mouth when coughing or sneezing.

Concurrent disinfection means that the patient's unit is kept as clean as possible. In addition to the daily bath and frequent changes of linen, regular dusting and cleaning are provided. A damp cloth is used for dusting. Dustbane keeps the dust down in sweeping. The nurse should avoid creating dust by shaking the sheets and blankets. All articles taken from the unit are sterilized or washed at once. Papers, letters, scraps, etc., are removed and destroyed.

Terminal disinfection is begun as soon as a patient is discharged. All papers, books, toys, etc., are burned. The linens and blankets are sent to the laundry where the following procedures are routinely carried out:

- 1. Sterilization of all white linens in a 1% liquid bleach. This is in the proportion of 2 quarts of bleach to 100 pounds of dry linen. The first wash is in water at 170° F. for 10 minutes followed by the second at the same temperature for 20 minutes.
- 2. Underwear and other washable articles Steri-chlor is used. (It is made from lime powder but with the bleaching agent removed.) Here 8 ounces of Steri-chlor is used to 50 pounds of dry clothes.
- Clothing infested with pediculi is autoclaved in dry heat for 30 minutes.

 Pillows and mattresses are autoclaved or sprayed with Izol solution and aired.

We use a variety of solutions to suit specific situations. Instruments are boiled or soaked in Lysol solution. Combs are placed in Zephiran solution. Jewelry is sponged with alcohol. Wash basins, gargle cups, kidney basins, soap dishes, etc., are boiled for ten minutes. Bed, table, chair, and wall are washed thoroughly with soap and water and aired, immediately after the mattress and pillows are removed.

To Discharge a Patient

Prior to discharging a patient, the bathroom is thoroughly washed. The clean clothing is taken in and deposited in the uncontaminated area. Towels and a bath mat are placed there also.

A board is placed across the tub on which are basins and a pitcher of water for a shampoo. The nurse washes the hair very thoroughly, then ties a towel around the patient's The patient remains at the end of the bathroom away from where his clean clothes, etc., have been deposited until the nurse has removed the basins, pitcher, and board. In the case of children, the nurse remains during the discharge bath. Otherwise, she gives instructions for the disposal of the contaminated clothes, prepares the bath, and indicates the clean attire. When he is dressed, the patient is guided to a clean room where he will be called

The bathroom is washed throughout with soap and water and left clean.

Editor's Note: Next month we will conclude Miss Shepherd's detailed outline of communicable disease care with instructions on how to look after a case at home and a summary of the main points in the nursing care of the various common communicable diseases.

Of the 162 Canadian veterans blinded in World War II, 55 were prisoners of war following their capture at Hong Kong. The condition of the latter was largely the result

of nutritional deficiencies while in captivity. Of the total of war blinded, 60 are reported as satisfactorily employed.

- Veterans Affairs

Recreation for Student Nurses

SHEILA M. OGILVIE

DID YOU EVER feel disgusted during training? If so, did you ever enquire the reasons for this feeling? You will probably have found that it derived from two separate sources: (a) a constant series of rebuffs or an especially strenuous period of work; (b) a sense of a lack of adequate recreation.

Ignoring the first, I shall try to point out three aspects of recreation—physical, cultural, and social — which I am sure can enrich student life.

Let us first think of physical recreation. We are only too well aware, all of us, that many student nurses flatten their feet from excessive walking and all develop a certain amount of muscle tone in their arms from lifting patients and mattresses. This is all exercise, of course, and we often felt quite worn out after it. The fact remains, however, that it is not balanced exercise and it is not carried on out-of-doors. There is so much walking involved in confined atmospheres that at the end of the day the tendency is just to flop down. is unfortunate and not conducive to the best health, for it is important, nay, I would even venture to say imperative, when one is all the time attending sick people, to get out-ofdoors and engage in some form of physical activity. If there is no provision made for the students' physical recreation, there is often no alternative but more walking. Now walking is an excellent activity and one which should be indulged in more frequently, but for student nurses, who do nothing else all day, it has only a limited appeal.

There are many excellent sports which produce great enjoyment and physical development concurrently. During the milder seasons of the year many enjoy tennis and there should be a suitable number of courts in connection with the school for that purpose. Organized games and

tournaments can be instituted which would encourage team-work and good fellowship. Some form of playing-field is very desirable, where base-ball, hockey, and any other athletics which the girls want can be conducted.

Indoor athletics are vital during the winter months. A fully-equipped gymnasium should, therefore, be a part of every school, where badminton, basketball, apparatus-work, etc., can take place. Expert instruction might even be introduced at regular intervals when the majority of the students could take advantage of it. If opportunities for swimming, hiking, riding, skating, and skiing in the vicinity are available, the students should be encouraged to participate in these, and special facilities, such as transportation could be provided for their convenience. In a word, nothing is so important as the maintenance of health and, once an excellent physical recreation program is established, the student will be able to study and nurse with greater zeal.

The next type of recreation to be considered is cultural, and the avenue to that is good books, good music, and good entertainment. fine recreation library in charge of a trained librarian should be at hand in the residence for the use of all students. A large and divers collection of books of a high standard is advisable, with attention to the classics, autobiography, travel, and modern thought. In addition, a periodical section is advantageous, where non-nursing magazines and weeklies of a reasonably high standard are a sine qua non. For many students, this library will afford an opportunity to develop a sound appreciation of good literature and keep them in touch with the larger affairs of the world without.

Music, too, is so much desired by many people that it is a shame if no facilities to play and listen to music are present in the student's life. Girls who sing or play instruments want to continue doing so even though they are learning to be nurses. To that end, a specially constructed sound-proof music-room should be available for all, where there is privacy for them to practise alone or in groups. A library of recordings to suit different tastes, stored in an adjoining room, suggests itself at once as a useful corollary.

As for general entertainment, the above-mentioned orchestral groups and scheduled programs of recordings from outside sources could provide much pleasure in the evenings and thus help to brighten the lives of the student body as a whole. add, in the same connection, plays, movies, and speakers prominent in their own field? Where the girls are cut off from outside interests, training can become a very stifling process: so much so indeed that after a while they find it difficult to converse intelligently on varied subjects. Any steps taken to avoid such a condition is more than worthwhile.

My third section, social recreation, provides for adequate mingling of students with other young adults who are not connected with nursing. It would be stimulating in the highest degree for them to feel that they have every opportunity to meet their friends and entertain them on their own premises in gracious surround-

ings. A home-like atmosphere means so much, especially to students who are so often far removed from their own homes and who must, therefore, rely solely on the hospital for the greater part of their social life. Dances held frequently are a great boost to morale and, in addition, parties among the students themselves and also shared with other groups in the community are valuable. Special events, such as a Christmas party, can be made into extremely happy occasions too.

Perhaps I may be regarded as asking too much when I mention all these encouragements for students and yet I do not think so. We ourselves have seen in our visits to institutions for delinquent girls that intellectual and physical recreation is far from being neglected. Why then should not similar or even greater facilities be forthcoming for young women who are devoting themselves to such a worthwhile cause as nursing? It must never be forgotten that girls in training are young and active and, as such, desirous of living their lives to the fullest possible extent. It is all the more important that they be encouraged to do so because training, of necessity, involves a certain exclusion from ordinary outside activities. Therefore let us develop physical, cultural, and social recreation for student nurses and make them healthier and happier girls.

Vitamin C in Potatoes

Do you know that one average-size potato, properly cooked, contains enough vitamin C to supply one-third of your daily requirement of that vitamin which is essential to your health? By properly cooked we mean potatoes should be baked, steamed, or boiled in a covered pot with their jackets on.

Vitamin C can be destroyed by over-cook-

Vitamin C can be destroyed by over-cooking, especially in rapidly boiling water in an open kettle. Those who eat boiled, pared potatoes are deriving great benefit from the energy-giving value of the potato, but are losing the vitamin values which could be so

easily retained.

Vitamin C is given credit by present-day nutritionists with being one of the most important inhibiting factors in preventing the occurrence of certain symptoms such as tender joints, headaches, low resistance to infection,

digestive and nervous disturbances, general weakness and restlessness.

Valuable for teeth: Ascorbic acid, which is found in vitamin C, is necessary for normal activity of certain cells which are responsible for laying down the calcified structures in teeth. A mild deficiency of vitamin C results in defective teeth and bone formation.

Baked potatoes, eaten along with the skins, are the most nutritious. By eating the skins you will get the benefit of all the minerals

which lie close to it.

Steamed potatoes are preferable to boiled because the elusive vitamin C, though easily destroyed when potatoes are cooked in water, is not as quickly lost when cooked in steam. If you must boil your potatoes, do so with

the skins on.

-Health News

Summary of the Working Party Report

WITHIN the past few months newspapers and journals have carried excerpts from and comments upon the Report of the Working Party on the Recruitment and Training of Nurses. This committee was set up in January, 1946, in Britain, by the Ministry of Health, the Department of Health for Scotland, and the Ministry of Labor and National Service. Its directive was to "survey the whole field of the recruitment and training of nurses of all types." In commencing the study, the Working Party realized that their objective "should not be to attempt to formulate interim proposals to remedy or palliate the difficulties of the present . . . but rather to assess, if possible, what nursing force, in terms of quantity and quality, is likely to be required in the future . . . and to suggest how best that force can be recruited, trained and deployed."

They were aware that numerous studies of nursing conditions had been made which had borne fruit to a limited degree but "a new departure in method seemed to be called for . . . to arrive at some degree of finality in considering these problems." This report indicates the wisdom of their

decision.

The study found that "to some extent the long-term solution of the problem of staffing the nursing services lies in reducing the burden of sickness." "Clearly the problem of sickness can be attacked quite as much by reducing the number of patients as by increasing the number of nurses . . . The proper stage for the estimation of sick nursing requirements should be subsequent to the optimal requirements of health nursing services." The rapid development of preventive services in the past quarter century and the accompanying reduction in the total amount of illness is abundant witness to the wisdom of this thesis. (In Canada in 1944, total maintenance

expenditures for general public hospitals in the care of patients was \$69,053,000 compared to the relatively small sum of \$6,456,000 spent on the general public health development

opments.)

The Working Party found, in studying the present conditions existing in nursing, that "nearly half the total number of nurses in hospitals, including students, have received fulltime education up to the age of 14 or 15 only. Another 30 per cent have received some further education . . . without reaching school certificate standard. One in every six has reached . . . matriculation standard but has not proceeded further. Some 4 per cent have been educated to higher certificate standard . . . 1 in 200 has a professional diploma or a university

degree."

It was found that some 55 per cent of the nurses transferred to nursing from some other employment, the inference being that these filled the gap between leaving school and starting to train with available work. The report suggests that "pre-nursing courses . . . for girls between 15 and 17 or 18 would make a valuable contribution to nursing recruitment." Regarding the desirable age for girls to enter schools of nursing they state " . . . it would seem that candidates should be accepted at the age of 18 years, though not younger, perhaps, but every encouragement should also be given to candidates of more mature years." They were definite in their stand that married women should have an equal opportunity both to enter the field of nursing and to win promotion following graduation.

Discussing the alarming problem of student nurse wastage, the report states "wastage.. occurs not simply from demanding too much of the duller student, who gives up the unequal struggle when confronted with too difficult a task; it arises also from lack of appreciation of the gifts of the

brighter student." A very detailed investigation was made into this problem since there was an average loss of 36 per cent from each annual intake of students over a 7-year period. Some of the findings included in the report are:

While some part of this wastage is undoubtedly due to the admission of candidates who lack the ability or the temperament to pursue the training successfully, the exceptionally high rate of wastage among student nurses very definitely suggests that they are expected to work and train under conditions which even many of those suitably equipped are not prepared to tolerate.

Generally speaking, there is a considerable sense of frustration and discipline is felt to be harsh and cramping and quite out of accord with modern notions of personal freedom...not referring so much to disciplinary requirements in periods of duty, but more to the restraints imposed upon a nurse's freedom in her personal life when she is not on duty.

aware of, or fail fully to appreciate, the outlook of the younger generation. . . . the difference in attitude between a nurse who gives up training and one who does not is a difference in degree not in kind. . . . they would leave not because they dislike nursing but because the conditions of training are to them all but intolerable. Those who leave do so . . . because they have reached breaking-point.

After reviewing the major reasons for wastage which centred around problems of hospital discipline, the attitude of senior staff, food, hours, pressure of work, the Working Party concluded that "nurses in training must no longer be regarded as junior employees subject to an outworn system of discipline. They must be accorded full student status so far as the intrinsic requirements of nurse training permit."

Experience teaches that . . . it is of little use merely appealing to hospital authorities to modify discipline or to adopt more understanding attitudes. The introduction of structural changes in the organization and staffing of training schools is certainly needed.

Emphasis is placed on the fact

that the present basic training places greatest stress on preparation for institutional sick nursing, instead of giving all nurses an understanding of their potential usefulness as health teachers. Moreover, endless hours are spent on "non-nursing duties which could be properly performed without any nurse training at all." From the data available, the Working Party estimated that the percentage distribution of training hours spent in nursing and domestic duties was: First year, 67% to 33%; second year, 76% to 24%; third year, 84% to 16%.

It would thus appear possible, by reorganizing the system of training and treating student nurses as students, to provide within a period of two years a training at once more comprehensive and more effective than that now given. In our view this wider training is essential if the preventive and curative aspects of nursing are to be properly integrated.

Their proposals for the new type of training would necessitate a complete revamping of the existing arrangements. Instead of the present three-year general training followed by an additional year for obstetrics or pediatrics, etc., the Working Party report recommends that:

... a course of training lasting two years might be devised for all nursing fields, of which the first eighteen months would be devoted to a common content for all students, and the remaining six months be concentrated study and training in a chosen field. In this last six months a student might elect either to continue with general medical and surgical nursing or concentrate on public health, psychiatric, or pediatric nursing, or on communicable diseases, including tuberculosis...at the end of which, (the two-year period), and subject to examinations, nurses would be granted provisional State registration and would be entitled to the pay, status, and title of State Registered Nurses. They would then be required to spend a third year in nursing practice under supervision before provisional registration would be confirmed.

One special feature of this scheme is that ... it would provide a basic training for public health nurses. In the past, training for the public health field has been superimposed at

the "post-graduate" level on hospital training. It appears doubtful whether a nurse, who has been in constant contact with sick people for three or four years, can so readjust herself during subsequent training so as to be able to assimilate the essential principles of social and preventive medicine.

We suggest that the State examination in the new scheme might be divided, as now, into two parts — the first taking place at the end of eighteen months and the second at the end of two years. The first examination would embrace the whole content of the common course; the final examination would be closely related to the specific content of the chosen period. . . . the student would qualify as a State Registered Nurse. . . . she would not, however, be permitted to engage in private practice, or be employed otherwise than under supervision, until she had completed a further year's work under an appropriate supervisor.

No training scheme is planned to produce a completely "finished" product with nothing left to learn. . . . too much should not be crowded into the actual training period. . . . we must distinguish between what belongs to training proper and post-training respectively.

... under our scheme the period of four weeks' maternity nursing included in the first eighteen months of training might be followed, in the optional period, by six months' intensive study in midwifery. Our enquiries ... suggest to us that it would be wholly desirable that nurses and midwives should have a common basic training, thus leading to unification of the nursing profession.

The Working Party recognized clearly that if the students are to come to their true status, definite conditions must be met. They must not be hampered "by the staffing requirements" of the hospital. "Adequate and stable domestic and nursing staffs" are imperative. "... the rotation through hospital wards and departments must be dictated by the nurse's needs as a student..." The immediate necessity for financial assistance for such a development becomes apparent at once. The report is definite on this matter:

The cost of training should be dealt with entirely separately from the general maintenance expenditure of the hospitals in which training is given. Without question the present financial dependence of nursing schools upon the finances of the hospitals to which they are attached nullifies any serious attempt to improve the training of nurses. Student nurses would cease to be employees of the hospital and would not be bound by contract to an employing authority.

Money is available from the public treasury for other forms of education. At last it is proposed that nurses' training be given the same form of financial backing.

Very positive recommendations were made regarding the working hours of students:

... the training day must be reduced in span so that it approximates as closely as is practicable to that of the normal working day and this involves the introduction of a three-shift system. . . . we have discussed the question with large numbers of nurses of all grades and, generally speaking, they declare their wholehearted preference for a shift system. We have not met any evidence that the shift system is not popular with patients or is bad for them. As far as student nurses are concerned, the day is now broken up into periods on the wards, in lecture rooms, or off duty, and is more fragmented than it would be in a shift system which would make it easier to systematize training. Among its many advantages may be counted the opportunities of non-residence, of having free time at the same hours as persons in other occupations, and avoidance of the insular and cloistered life of an institution. ... so far as student nurses are concerned, we consider that the span of daily duties should not begin before 8 a.m.

The present plan of recompensing students for services rendered would necessarily be altered. The Working Party suggested that:

Students should receive, in addition to board residence (or allowance in lieu) and free tuition, a grant to cover personal expenses to be paid by the training authority.

A variation on one form of the central school plan which is being studied in Canada is proposed as the most feasible means of bringing these proposals into fruition:

Hospitals and public health agencies will together form a composite training unit covering the whole nursing field. Students would be students of the unit passing from one institution to another as necessary in the course of their training.

Teaching resources of the several institutions forming a training unit would be a common pool and full-time teachers made mobile so far as necessary to ensure the best qualified instruction in the various subjects of the curriculum. . . . to ensure continuity of teaching and supervision, it will be essential for ward and departmental sisters to retain a distinct teaching function. . . . the content of nurse training should be strictly determined by one central criterion, namely, the extent to which items of training contribute to reduce the incidence or duration of sickness.

Before terminating their report, the Working Party considered the matter of the over-all organization which would have jurisdiction over the examinations, registration, etc., as well as providing for continued research in nursing.

body covering all fields of nursing in England, Wales, and Scotland. This General Nursing Council for Great Britain should include, in addition to government representation and nurses elected on a regional basis, a due proportion of university and other educational representatives.

How would these proposed changes affect the status of the assistant nurse group who today are required to take a two-year training? Would a total of more graduate nurses result from the more careful selection of candidates for training and the revamped form of education? The Working Party concluded their report with

statements covering these points, as follows:

For some time it will be essential to use the services at least of those assistant nurses now employed, but such a grade with a two-year training should not be perpetuated. The roll should be closed at a given date and to fill the gaps their duties should be allocated partly to trained staff and partly to nursing order-lies who would replace assistant nurses.

The additional staff required to give effect to student status and the three-shift system cannot be less than 22,000 to 24,000 trained nurses and some 14,000 nursing orderlies. This would raise the trained nursing force from 88,000 in December, 1945 to 112,000. . . . the requirements could theoretically be met in five years by reduction of wastage, but this takes no account of increase of staff to allow for expansion. All restrictions on the employment of married persons in the nursing services must be removed, part-time service developed, and the use of male nurses extended. . . . to provide for existing needs and training reforms would seem to require a trained nursing force of not less than, say, 120,000 to 125,000.

The report fails to indicate just where the desirable candidates for the schools of nursing are to come from or how the personnel to perform the domestic duties are to be retained within the hospitals. The full report merits careful study by Canadian nurses. Our schools of nursing have been faced with many of the problems which beset those in Britain. Student wastage, too many non-nursing duties, etc., we have them here! Suggestions have been made that our methods of training are antiquated and need to be remodelled. Full understanding of the implications of this report will strengthen Canadian nursing leaders as they seek for a solution to our problems.

Food Models to Color

Four sheets of outline drawings of foods, closely approximating actual size, have been produced by the Nutritional Division for practical study of individual foods and menuplanning. The sets contain suggestions for breakfast, lunch, dinner, and extras. The foods are outlined in black and white on

manila paper and are to be colored, cut out, and mounted. For classroom use a suggestion is to mount them on flannelette, felt, or velveteen. They will then adhere to a similarly covered stand. Write to your Provincial Department of Health.

— Home Economics Newsletter

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Practical Side of Evaluation

PHYLLIS E. (REEVE) BLACKALL

URING THE last few years there has been a growing acceptance of evaluation by students, staff nurses, and supervisors in the Metropolitan Health Services in Greater Vancouver. We have been particularly interested in the evaluation of students who have come to us for field work in public health nursing from the University of British Columbia and have been experimenting with various methods and techniques for some time. We have also been trying to make good written evaluations of our staff nurses a part of the supervisory program. We want these reports to be useful: not only indispensable tools when making appointments, transfers, and promotions, but also to the supervisors in their guidance of the members of their staff. Since these two evaluation programs have been closely interrelated, we have learned something from each which has benefitted the other.

From where we stand now, several facts stand out. First, although it is more difficult to evaluate accurately the work and performance of a student who has a relatively short time with the agency, compared to the staff nurse, it is easier to write the evaluation. It is also easier to give constructive criticism. Perhaps this should not be so, but the fact remains that it is easier to be completely objective about a person one does not have to live and work with daily. At the same time, it is more satisfying

to make a good evaluation of a staff nurse, to see it put to use, and to watch the nurse's continued development, than it is to write an evaluation of a student, and then not have the opportunity of watching the use she makes of it.

STUDENT EVALUATIONS

Because it is easier to write student evaluations we have obtained quicker results. Because we prefer to do things well or not at all, we have spent considerable time in studying theories and putting them to work. Ruth Freeman's book, "Techniques of Supervision in Public Health Nursing," has been invaluable, both for its philosophy and for its practical suggestions. Conferences with the nurses to whom students are assigned are held regularly. There is much free discussion regarding evaluation, its usefulness, its difficulties, methods. and so on. Sample evaluations are studied, actual cases discussed, and ideas exchanged among the nurses as to how to express themselves. How to criticize objectively, in ways the students will appreciate and not resent, is the part of evaluation brought up most frequently.

We believe that the evaluation should be objective; that it should be considered over a period of time; and that the opinions expressed in it must be based on facts as well as on general impressions. Therefore, each person having any student supervision to do is asked to keep written notes. These are used to gauge the student's progress and to illustrate the evaluation with concrete examples if any commendations, criticisms, or recommendations seem to require explanation. The Department of Nursing and Health at the university makes this note-keeping easy for us by providing an evaluation guide for each student. Most of the nurses keep notes in the appropriate sections of the guide and refer to them frequently during discussions.

We believe that evaluation is given primarily to help the student improve and strengthen her performance, not just to enable the university to follow her development. Therefore, we ask the nurses to give continuous verbal guidance all during the field work period. We also ask them to discuss the evaluation guide with their students, preferably midway through and again at the end of the period. Most of the nurses carry out the former, and many the latter suggestion very well. They do it so unobtrusively and tactfully that their students get a good deal of information regarding their strengths and their needs without realizing that what they are getting is good supervision and evaluation. The nurses find relationships easier if their students are more or less their own age, so we try to arrange this for them. It is not always possible, but one combination we can usually avoid is having an older student with a young, recently graduated nurse which sometimes leads to feelings of insecurity for the nurse.

We believe that supervision should be creative and that evaluation should follow through and be creative also. It is not always easy to maintain this attitude when discussing a student's performance or when writing an evaluation, especially if one has found it difficult to remain truly objective or has felt hypercritical toward the student. We try to remember always that we are not seeking to pour people into moulds, to make of them more creatures like ourselves, nor are we seeking to change or reform; rather we are trying to help people like ourselves, but having less experience perhaps, to perform effectively, using their own abilities in satisfactory (and satisfying) ways. We want to help them to realize their strengths and weaknesses, to face both with equanimity, to make good use of their assets and to make assets of their liabilities.

One point which is worth stressing is that an explanation is given to the students when they come to the agency of our objectives and methods of supervision and evaluation. This helps to remove from their minds the misgivings some students still seem to have regarding supervision.

In preparation for writing their evaluation, some of the nurses have found it helpful to have a conference with supervisors midway in the field work period, but anything more than informal discussions is not always Conferences are held in each unit following the field work so that the senior nurse can integrate her findings with those of the other student supervisors. Participants usually bring their written notes to this conference. Some of the nurses like to have their evaluation already completed in rough form so that it can be read, criticized, and reconstructed if necessary. It is sometimes valuable at this time to have a discussion leader who has not had working contact with the student. She can often keep the discussion from getting side-tracked with unimportant detail, or from taking too much time twenty minutes is usually sufficient for each evaluation. She can also help to keep discussion objective. She can say such things as, "I appreciate the fact that this student does not do things the way you like them done, but what results is she getting?" or "This student seems to have a good deal of knowledge at her fingertips. Does'she put it over to families at their own level? Is she tolerant of other workers?" and so on. objective discussion leader is particularly helpful with "difficult" evaluations, and no one will deny that there are such. Nearly all nurses appreciate help with ways of making

criticism tactful and easy to take, and in following it up with practical constructive suggestions. We usually follow the guide in our discussions. The written evaluation is in narrative style, however, as this is freer and more readable than an itemized report. There is more scope for showing warmth and sincerity in a narrative piece of writing and these aspects are important.

One detail of evaluation we endeavor to avoid is the use of such phrases as: "Ability quite good, interest fairly good, performance quite good, etc." This phraseology can be of little use to the university or to the student, and is certainly of no value to a prospective employer. Instead of this we would probably write some-

thing like the following:

This student shows average ability in teaching in homes and in child health centres, but is most adaptable in schools, where she shows an aptitude for work with elementary school children. While most of her interest lies in this part of the program she shows an eagerness to learn more of other phases of the work. She will need considerable supervision in tuberculosis visiting as her knowledge seems limited and contributes to her insecurity. With supervision and experience she should give an acceptable performance in any type of public health program.

There is one more step in our evaluation of students which we all appreciate. The personnel at the university, who receive the evaluations and discuss them with the students, let us know what they think of them. Sometimes the evaluations do not give as clear a picture as they might; sometimes there are important points missing. We are glad to know of these defects so we can avoid them another time. Sometimes we ask a nurse to rewrite or reword an evaluation before sending it to the university, but this is a rare occurrence.

STAFF NURSE EVALUATION

Our health service is made up of six health units, the nursing staff in each consisting of a supervisor and from five to fifteen staff nurses. In

the central office there are the director of nurses and four consultants, including a nutritionist. The unit supervisors and the central office staff form our supervisory group which meets twice a month for purposes of study and discussion. This past year, we re-opened a long-term study of evaluation in order to add to our knowledge of it, to improve our attitudes, and also to adopt some reasonable form for the written evaluation. The fact that the supervisors have been helping the nurses write their student evaluations has taught us a good deal. Miss Freeman's book has, again, been invaluable, especially those chapters on Studying the Ouality of Nursing Service, Techniques of Leadership, Observation of the Nurse in the Field, and Evaluation of Staff Performance. These we have studied and discussed in some detail, always trying to relate the theories to our own situations. We find that we can duplicate every example given by Miss Freeman and add a few more. We wonder if more adequate evaluation might not have avoided such things as leaving supervisory talent too long unrecognized, or having too little information from which to send to a prospective employer a recommendation for a former staff member. We select a different discussion leader for each chapter studied, and each leader brings up practical points for discussion. We have found our conferences so satisfactory that we intend to treat the remainder of the book in the same way, planning to spend the first hour of alternate supervisors' meetings in studying ways of overcoming our own difficulties.

We have been wondering for some time in what order we should write our evaluations. Now, having found the university's guide so successful in fulfilling its purpose, we have drawn up a similar modified guide, the outline of which is included, here, for our own use. We follow this using a free, narrative style, illustrated with examples taken from the supervisory record. (On a form drawn up for the purpose, the supervisor plans her visits to and with

Guide for Writing an Evaluation of a Staff Nurse

I General Impression:

- (a) Personal qualifications Reliability, adaptability, appearance, judgment, resourcefulness, manner, punctuality, interest, sincerity, sense of responsibility, health, etc.
- (b) Social vision.
- (c) Professional and community activities.

II Performance:

- (a) Approach to lay individuals and groups.
 Approach to professional individuals and groups.
- (b) Relationships with parents, children, teachers, private physicians, staff and other workers.
- (c) Organization and planning.
- (d) Recognition and analysis of problems.
- (e) Teaching Subject matter, methods, results.
- (f) Records.
- (g) Student program.

III Progress and Recommendations: (Be specific)

each nurse. Progress notes are kept on what the supervisor observes and the plan modified according to the nurse's needs.) We have more detailed guides which are really a series of questions concerning various phases of our work. These stimulate the supervisors' thinking and act as reminders. Although they are too detailed to be followed exactly, they prevent some parts of the work being stressed to the exclusion of others.

New staff nurses are made aware of the type of supervision and evaluation we are trying to carry out, when they are first introduced to the agency. Also, we include the question guides in our work manuals which are available to all nurses in their schools, child health centres, and unit offices, so that they may know in detail what is expected of them and along what lines they are being appraised, and can evaluate their own performance. Because of this and because of the work being done along these lines in universities, we find that our younger staff members, almost without exception, accept and welcome evaluation. The reaction of older staff members who have never seen, until recently, written evaluations of their work, varies from complete acceptance to rejection. We respect both reactions and have not made reading the evaluation compulsory.

In preparing evaluations we all find similar difficulties confronting us, i.e., how much to say, what to say and how to say it, how to be helpful, how to criticize constructively, how to be objective and, at the same time, warm and sincere; how to create strengths where there are weaknesses and, of course, how to find time for it Feeling that we could help one another with some of these difficulties we decided to get down to actual cases rather than hypothetical ones. Each of the unit supervisors agreed to write an evaluation of one of her staff nurses, calling her Miss X, and to bring it to a meeting to be studied from the point of view of length, completeness, value to an employer or supervisor, acceptability and usefulness as far as the nurse is concerned, etc. This experiment is only beginning, but we can see already that it has practical possibilities.

We do not expect perfection in anything so difficult as evaluation because we realize we are all human beings in whom perfection is an impossible goal. We feel we must approach each evaluation with humility for our own right to evaluate and respect for the person to be evaluated. We still have to fight a reluctance which many of us feel—to put our findings down in black and white for someone to read, and perhaps object

to, before signing. However, we are overcoming this reluctance and it is becoming easier to convince nurses that we are not sitting in judgment, one person on another, when we appraise them and record our findings. As supervisors, we realize that we have accepted a responsibility to help others achieve quality and satisfaction in their work through evaluation.

Enuresis

NORA TILLSON

I may exaggerate, I hope I do, for where there is no exaggeration there is no love and where there is no love there is no understanding. It is only about the things which do not interest one that one can give an unbiased opinion; and this is no doubt the reason why an unbiased opinion is valueless.

- Biography of OSCAR WILDE

I quote this as an alibi for I know that I have been guilty of wishful thinking, over-optimism, in pursuing the subject of the prevention and cure of enuresis.

Bed-wetting has been a source of endless work and worry to mothers, mortification and discouragement to the victims. It is one of those things which has only been mentioned in whispers, and, until I embarked on this project, I had no conception of its prevalence or the unhappiness which it entails.

Several years ago a boy of fourteen was brought to the school doctor for help. He wanted very badly to go to camp but was unable to do so because of enuresis. The advice given was to restrict fluids after supper, and to get him up often enough to keep him dry and, because of his age, to make him assume the responsibility for getting himself up with the help of an alarm clock. He did not go to camp!

This incident nettled me, but I could find nothing of help on the subject until I read in a book on psychology that for one case of bedwetting due to disease, there were nine attributable to psychological causes. The psychological factor underlying enuresis was said to be a loss of feeling of security. (I leave the problem of disease to more com-

petent authorities and pursue my own

theory.)

With the above knowledge as a starting point, a new idea began to take shape. When I ran across three cases of enuresis within a short time, I was rash enough to ask the mothers to try an experiment:

1. To have the urine checked to eliminate

the possibility of disease.

2. Restrict fluids after supper.

To get child up often enough to keep him dry and while doing so to be gentle and show affection.

These mothers reported back some time later that the plan had worked and the children were cured. Further confirmation of my theory came from another mother who had observed that her daughter never wet the bed when she occasionally slept with her.

This initial success made me want to pursue the study more intensively and I outlined my ideas to the provincial supervisor with a view to getting permission to proceed. During the discussion she said, "If you are able to cure it you should be able to prevent it." Thus a new angle that was definitely intriguing was introduced.

During home visits I purposely tell mothers about the work I am doing with enuresis. This serves to locate new cases, to promote discussion of allied troubles and, by showing contributing factors, to try to prevent the occurrence of it in that home.

SUMMAR	Y OF	RES	SULT	SIN	63	CASI	ES
Cured							. 33
Controlled b	y get	ting	up c	nce.			. 11
Controlled b	v get	ting	up t	wice			.3

Children too young to expect control	- 5
Moved and so lost track of	3
Progress not yet known	4
Apparently not helped	4
SUMMARY OF POSSIBLE CAUSES	
Disease	2
Pin worms	4
Fear	5
Mother in hospital	1
Suppressed anger	- 1
Stress of strain in family life	12
Tealousies	38

The first step in dealing with enuresis is to learn the family setup, number of children, where the child in question fits in, explaining to the mother that 90 per cent of this trouble is due to psychological factors. I try to get the history of the trouble. Was the child ever controlled? When the control was broken, what happened at that time that might account for it? It is essential to get it across to the mother that bed-wetting occurs when the child is asleep and, therefore, no blame should be attached to him.

The child should be given plenty of fluids during the day but restricted at supper time and nothing afterwards.

A system of getting up is planned with about a three-hour interval, this to be regulated according to individual need. If at one specific time the child does not need to get up, and this occurs for two or three consecutive nights, omit that time and so on until one getting up is sufficient to keep him dry.

These children are quite quickly controlled and in the first flush of success the mother may stop getting the child up. I feel there is danger in this, and that if child breaks control again, the second time it is harder to get results. Getting the child up at the time the mother goes to bed should be continued for some time. Each time the child is roused an opportunity is given for showing affection in some way, thereby giving him that extra attention he craves and needs.

The fact which seems to arrest the

mother's attention is that enuresis can and does occur from such a simple and normal happening as the advent of a new baby into the home. The following case histories will illustrate the types of problems which may be encountered:

Mary Barbara, at two years of age, was taken to hospital to have a cleft palate repaired. She had been toilet trained by then but when she returned home she had broken control. At four years she was placed under a child specialist and two years later she was still not trained. I came in touch with her at the time of her complete physical examination on starting school. In three weeks she was controlled and I assumed she was cured. Some months later I met her mother and she told me that Barbara was in difficulty again, that she had developed diseased tonsils and her hearing was affected. She has since had a tonsillectomy, resulting in improved hearing. She is not improved otherwise. The mother feels that she should drop all efforts in this regard for a time, then consult family doctor for help. This seems sensible to me as there has been possibly too much attention given already.

This case illustrates strain: Earl is seven. For the first three visits I seemed to get nowhere with his mother. On the fourth, I felt I had her undivided attention for the first time. There are three children - a boy of nineteen, a girl of sixteen, and Earl. The mother and father are very energetic and so is the daughter. The two boys are slow both mentally and physically. As a result they had to be dressed and fed long after they should have been able to care for themselves. There are aunts and uncles on both sides of the family who are better off financially and whose children are quicker at school. There has been considerable rivalry as a result and corresponding stress to the two boys. Earl has never been controlled. The first boy is very dependent on his mother. Getting a job, he loses it because he will not get up early enough to get to work on time.

There may have been some complication of fear in Earl as well as stress, fear of going up to bed alone. His bedroom is upstairs while his parents sleep down. As part of treatment on going to bed he is put in his parents' room and when they wish to retire he is taken to the toilet and put upstairs. He is now controlled after eight months.

His disposition has improved and his personality is developing.

This is another instance of *strain*: Richard is three. His mother asked me in clinic if it was merely coincidence or if it could be possible that his bed-wetting could result from his grandmother's presence. It stopped when she left. She was much too critical, scolding and nagging the child.

Carol is four, another case of strain. There are three children. Deserted by her husband, the mother was forced to come to her mother's home, making eleven persons living in four rooms. It was suggested that she restrict fluids after 6 p.m., get the child up so as to keep her dry and give her extra loving. I felt rather hopeless about this situation and was indeed astonished when in two weeks the child was cured.

The one case of disease was a boy of eleven. An examination of the urine showed excessive acidity. He had some difficulty during the day in control of the bladder also. After medical treatment for the bladder trouble, his enuresis ceased.

Suppressed anger: Grant was aged eight. This boy's mother heard me talk about enuresis to a group of women. I went to the home about four weeks later, because Grant was reported ill in hospital. There was very little discussion about that. The talk centred on the fact that he had been cleared of his enuresis before having to be hospitalized. The story was that the mother began to study the boy after my talk and realized a rather amazing fact. When the time came for Grant to go to bed he was told to do so. He complied without fuss but showed resentment. invariably wet the bed. When given ten minutes warning he went up without anger and the trouble was cured. He did not break control while he was away and he was very ill. I wonder if you can imagine the mother's pride in her boy.

YJealousy: You will note the large percentage of cases occur under the heading of jealousies. James, aged three, started wetting the

bed after his mother came home from hospital with a new baby. I learned about him in making an infant welfare call. He was cured very quickly with the routine treatment of restricted fluids after six, getting up as required, and that extra loving so needed.

Gordon, aged eight. This boy's mother had to go to hospital a year and a half ago. When she returned Gordon had started wetting the bed. I picked this case up in making a call for another reason. I explained treatment and returned a month later to discover that Gordon had had no further trouble since my first visit. It seems his mother had had a habit of saying to him when he came up close to her, "You know you are my favorite, Gordon." She forgot to do this on her return from hospital. The first night when she got him up around eleven, she said this to him and, looking up in surprise, Gordon said, "Am I mother? I thought it was Johnnie." He has not broken control since. He started waking himself at night, first twice and now only once.

There are five children under the age of three. I have made visits to the homes but have warned mothers not to try too hard to cure this yet. Psychologists state that children can be harmed by too early habit training and I am not sure of what is considered too early. Wayne is not three until March. This child was referred to me by his family doctor. He had, for some unknown reason, become afraid of the toilet. With the lure of a new book given only when he was using the toilet, the fear was overcome. Wayne cleared for a time but relapsed when he took a cold. On the whole there is improvement but again I stress the fact that training may have been started too soon.

Almost every visit produces other facets of emotional needs. If any public health nurses are feeling bored with their work I can promise them a renewed interest, a project which brings great satisfaction and happiness.

Year End Thoughts

He has achieved success who has lived well, laughed often and loved much; who has gained the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem or a rescared soul; who has never lacked appreciation of earth's beauty or failed to express it; who has looked for the best in others and given the best he had; whose memory is a benediction.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

A Study of Isolation Technique

CLARA R. AITKENHEAD

THE Committee on Instruction of I the Province of Quebec became inspired to review nursing procedures relating to isolation technique as a result of the confusion arising in the minds of student nurses, especially those who had affiliated from smaller schools, regarding the effectiveness of various methods and disinfectants employed, as well as desirable strengths of solutions and length of time required for safe disinfection. This important subject was discussed under four headings: (1) safety; (2) efficiency; (3) simplicity; (4) uniformity.

The committee is indebted to Dr. Frederick Smith, Dean of Medicine, McGill University, formerly professor of bacteriology, who is keenly interested in nursing techniques. Dr. Smith contributed very generously of his time in giving advice and

making recommendations.

The complete technique was discussed from a broad point of view, allowing some flexibility in order to be practical and applicable in hospital or home. The solutions recommended were those commonly found in most hospitals. Emphasis was placed on cleansing, strength of disinfectant, and length of time necessary for safe disinfection. This study stimulated keen interest among instructors and supervisors, and represents the result of excellent group participation.

Proposed Procedures

LINEN—in hospital: Put through laundry and washed the same as ordinary linen. Temperature of water should be 165°F.

LINEN—in the home: Immerse in water and bring to boiling point. Then can be washed or sent out to laundry.

As a precaution for those handling the linen from ward to laundry, contaminated linen should be put in a specially marked bag, untied when ready to be washed, linen put into washing-machine by holding outside corners of bag, and dropping contents into machine. The outside of this bag should not be contaminated. Linen from the beds of patients with active tuberculosis, or with venereal disease when there is a discharge present, should be considered contaminated. Linen from pneumonia patients need not be separated. Linen from infants with congenital syphilis with open lesions or nasal discharge should be treated as contaminated. If linen is grossly contaminated with urine or feces, as in typhoid fever, it should be soaked in either Izol 2%, Lysol 2%, Creosol 2%, or Formalin 10%, and allowed to soak, fully immersed in the solution, for one hour. It can then be rinsed and sent to laundry. Chloride of Lime is not recommended. It is not always dependable due to uncertainty regarding freshness.

WOOLLEN BED BLANKETS: Cannot

be disinfected by washing since too hot water destroys them. Could be autoclaved but this is also hard on wool. Not considered grossly contaminated since they are protected by spread and top sheet; therefore should be sent through with regular laundry inside a marked bag (stating they are woollen blankets). This is considered sufficient. Exposure of woollen blankets to special ultraviolet ray lamps will not disinfect them. Flannelette blankets are recommended instead of woollen ones.

Mattresses and Pillows: Cannot be disinfected by airing or use of chemical disinfectants. Can only be done safely in a mattress sterilizer. Not considered grossly contaminated since more protection is afforded by mattress cover or pad and bottom sheet. Bed rubber also protects mattress. Pillows used for tuberculosis patients could be autoclaved.

DISHES: Scraped and cleansed of food with paper napkin as clean as possible—immersed in water with tight-fitting cover on container, and allowed to boil for three minutes. Then washed in hot soapy water and rinsed in very hot water. Towels for drying dishes should be scrupulously clean, otherwise disinfection is of little, if any, value. If hot enough water is used to rinse dishes, it is better to allow them to dry without use of towels. Small sterilizers for use on wards are available for disinfection of dishes.

ENAMELLED WARE: When cleansed, immerse in water and boil for three minutes, same as dishes.

Gowns: Should be changed when soiled, or once daily.

BOOKS: Impossible to disinfect. Destroy.

STOOL AND URINE—from typhoid fever and other intestinal diseases: Covered with an equal amount of either Izol 2%, Lysol 2%, Creosol 2%, or Formalin 10% and allowed to stand for one hour before being discarded down toilet or hopper. The disinfectant should be well mixed with the feces which has been broken down as much as possible. Chloride of Lime is not recommended as a dis-

infectant unless it is known to be absolutely fresh.

BATH WATER—from typhoid fever patients: If not grossly contaminated from urine or feces, considered satisfactory to pour down hopper or toilet. If grossly contaminated, treat same as urine and feces.

Masks: If a mask is once removed from the face it should not be reapplied but a clean one substituted. If plastic masks are used each person should keep his own, washing it in

green soap and water.

Post-Cards: Patients should write cards instead of letters. If patient's hands are clean and he writes cards on a clean surface and avoids droplet infection, they should be safe for mailing. Cards written by active tuberculosis patients should be autoclaved. Cards, letters, and magazines which patient has received while isolated should be burned when he is taken out of isolation.

PURE RUBBER: May be disinfected by boiling for five minutes. Boiling is satisfactory for Levine tube provided water is allowed to run through tube.

SHEET RUBBER: Rinsed well in cold water, then immersed in water tested with thermometer—at 165°F. When this water has cooled sufficiently, wash rubber well, using soap, then rinse well under running cold water and dry thoroughly. This is considered sufficient for rubber sheets used after any disease.

CLINICAL THERMOMETERS: Individual thermometers, or one thermometer per patient essential. If kept in individual containers it is satisfactory to keep them in plain water which is changed daily. If not kept in individual containers, then there should be sufficient thermometers to go around all patients so that disinfection between patients is not necessary at time of taking temperatures. Thorough cleansing of thermometer with soft tissue before immersing in disinfectant solution is stressed.

Method suggested when thermometers are not kept in individual containers: Have sufficient thermometers for number of patients (one for each patient) which have been disinfected

and, therefore, need not be kept in any solution. When thermometer is removed from mouth it should be cleansed well with soft tissue to free of mucus, immersed in a soapy solution—then, when all temperatures have been taken, cleansed thoroughly in a soapy solution, immersed in carbolic solution 5%, and allowed to stand in this for one hour. Then they should be rinsed thoroughly in cold water, dried, and stored safely in covered container. Lysol 2% or Formalin 2% might be used as disinfectant. This thermometer technique is recommended for use in general hospitals.

CONCURRENT DISINFECTION OF ROOM—Furniture: Damp dusting daily. Floor: Sprinkled with chemically treated "sawdust" which prevents dust from rising, then swept with brush. In a general hospital, keep

brush and dustpan in room during period of isolation. If floor is grossly contaminated it should be washed immediately. Floor may be swept with gown on, this gown being discarded immediately after in exchange for a clean one.

TERMINAL DISINFECTION OF ROOM: Should be left for half a day if possible, before attempt is made to clean it, to allow dust to settle. Following respiratory diseases, ceiling and walls should be washed. Special ultraviolet ray lamps are available for disinfecting rooms—exposure one halfhour. (It is not recommended that woollen bed blankets be exposed to this lamp for disinfection due to lack of penetration.) Furniture: Wash well with soap and water, dry. Floor: Washed. Brush and dustpan washed and dried.

Expansion of Clinical Facilities

HELEN E. PENHALE

THE EXPANSION of clinical facilities is just another way of saying that we must endeavor to provide more nursing service for the public. One of the foremost objectives of postwar social reconstruction is the organization in the very near future of a truly comprehensive service for the nation.

The present shortage of nurses is due to a combination of factors. There has been a constant development of new forms of health service; more and more is being done for the health of the people, and more and more hands are needed to do it. Pre-payment plans for hospitalization and the new maternity act are but two of these forms of service here in Alberta. More hospital beds are occupied now than before the war. In 1929, Alberta had 3,724 beds or 5.7 per thousand population. In 1945, we had 6,178 beds or 7.4 per thousand. Patient days have steadily risen from 807,894 in 1929 to 1,499,029 in 1945. This means that today more hospital beds are occupied

than ever before, and still hundreds of patients await admission. There are demands for nurses in other fieldsindustry, public health, etc. Many of the nurses who came out of retirement, or who postponed retirement, to help during the emergency in the past few years have now retired to enjoy a well-earned rest. a vicious circle in the shortage itself. A short-handed staff means an overworked staff and strained working conditions. Thus wrong impressions of the real nature of hospital life and work are created and people are discouraged from choosing nursing as a career. To date, recruitment has not fallen off in Canada. This is not the case in the United States. Even in the best schools recruitment has fallen off. in one school from 60 down to 12!

We say we have not enough nurses. How many do we need? The ratio of nurses to population, as estimated by Dr. Thomas Parran, surgeon general, U.S.P.H.S., is 1 to 285. Enough nurses

means that we would not only administer the necessary nursing care to the sick but would also be able to carry on a full preventive and positive health program. Do we in Canada have a ratio of 1: 285? British Columbia has 1: 234, Saskatchewan 1: 579, Canada as a whole 1: 350, and the U.S. 1: 400. In Alberta we need 786,000 (estimated pop.) ÷ 285 = 2.758 nurses.

Our present resources include those in active membership (1946, A.A. R.N.), 1,860, temporary permits, 109, for a total of 1,969, or a shortage of 789 nurses below the desirable mini-Where are we to get this mum. needed 789 nurses? Our annual loss of nurses from nursing is greater than our gain from new graduates and nurses coming into the province from elsewhere. Our existing resources just cannot fill our needs. Let us look at our annual membership for 1946:

Annual renewals, 1,441.

Annual membership increase (1946 graduates), 262; annual membership increase (prior to 1946), 18; reciprocal registrants, 139; totalling 419, with a grand total of 1,860.

Annual exemptions, 504, made up of such causes as: Marriage, 265; illness, 13; residence outside Alberta, 213; retirement, 9; unclassified, 4.

Thus, in 1946 we had 85 more exemptions than new members.

In order to continue to provide 262 graduates each year, each school of nursing in the province must be used to capacity. Methods of selection of students, even though made with extreme care, still leave us with a loss of 12.5 per cent in Ontario, from 30-70 per cent in Great Britain, and for Canada as a whole 15.56 per cent. The survey conducted by Dr. and Mrs. Bixler in Michigan indicated that poor scholarship accounted for the greatest part of the loss. Our methods of selection will have to be improved now that Alberta has a new educational standard unless we accept as our standard for nursing anything that is "warm and walking." It seems obvious that our present facilities, even if taxed to their utmost, cannot meet the need.

Is it possible to import nurses? In 1946, 7 per cent of the total nursing membership were reciprocal registrants—a total of 139.

Does the answer lie in opening more schools? The majority of the smaller hospitals do not offer a sufficiently varied experience to the students. The Weir survey suggested that all schools be closed that were connected with hospitals of less than 75 beds and a daily patient average of under 50.

The preparation of another type of worker will help to a degree. training of nursing aides is well established in most parts of Canada. There are more than fifty schools in the United States with some degree of legal control for this group in twenty states. In Alberta, this type of worker spends 10 months in preparation— 3 months of theoretical instruction. 3 blocks of 2 months each of practical experience in general, tuberculosis, mental, and/or chronic hospitals, and a final month at the school for review and examinations. She is prepared to give care to the sub-acutely ill, the convalescent, and chronically ill who require nursing service at home or in institutions. She will work under the direction of a licensed physician or a registered professional nurse. There are specific controls and limitations of her activities. Both the public and the professional nurse have been protected through legislation set up to control this group.

During the past year the Alberta Educational Policy Committee has been studying the possibilities of preparing more students through setting up affiliations in tuberculosis and psychiatric nursing. The possibility of using rural hospitals for internships has been studied. We have obtained a great deal of information from other provinces and from south of the border. A suggested affiliation contract and tentative course outlines have been set up covering the experience in each of the three areas tuberculosis, psychiatry, and rural At a meeting of reprehospitals. sentatives of hospitals, schools of nursing, etc., held in April, 1947, a resolution was passed that the A.A.

R.N. send to the chairmen of hospital boards a brief covering the reasons for affiliation and encouraging their co-operation. The committee plans to continue the study and before too long we hope our students will have affiliations in each of these services.

The academic requirements for admission to schools of nursing in Alberta have been subjected to revision. With this comes the necessity to review the Regulations Governing Schools of Nursing in Alberta. The regulations were last reviewed in 1943. An adjustment of these regulations and the increasing of clinical facilities still does not begin to solve the shortage to which we referred.

Another factor we must consider is the nurse of today. A decade ago, the nurse was trained primarily to give care to the physically ill. Today, she must be prepared to provide additional functions. She interprets to the patient the discoveries of medical science and the place of the hospital in the field of health promotion. She serves as one of the many health workers engaged in programs for the prevention of disease and promotion of health. Finally, she teaches the use of personal health measures and community resources. Nursing education must be in accord with the type of service the public expects nurses to render. The plan of educating nurses by requiring them to pay for the greater part of their education by their services will have to be changed before nursing education can attain the ideals of a sound profession. The time has passed when we can look back and reminisce about the good old days. Reminiscing leaves only a sentimental glow that casts no light on the path ahead. The majority of the students in our 169 hospital schools across Canada are in schools financed, controlled, and maintained by hospital boards. The patients in these hospitals should not be expected to pay for nursing education in their hospital bills. Nor should the student's education be sacrificed while she provides nursing service for the hospital. If we continue to exploit her, her education and future contribution to the health of the nation is jeopardized.

A different type of nursing education is being considered—in fact many new ideas are being presented as the way out of our present dilemma. As a project to improve nursing education in this province, the Central School of Nursing is being studied. This is not a new idea. Isabel Hampton Robb talked of it fifty years ago. She proposed it as a means of increasing enrolment in schools of nursing and as a means of improving standards. By 1941, there were nineteen centralized teaching programs and five central schools in the United States. A centralized teaching program, covering the preclinical period, was discussed in this province in 1940. The planning committee does not advocate this form of centralized teaching program now. It implied a program which centralized part of the instruction for a definite period of time, for example, four months. We are advocating a Central School of Nursing, one whose administrative and educational personnel are organized so as to constitute an educational entity, and where the students' clinical experience is secured in more than one hospital and additional agencies.

There seem to be many advantages to this plan. They are:

Improved instruction in schools connected with small hospitals; more adequate instruction ensured in the basic sciences; more standardized education for all students in all schools in a given area; better nursing services for the sick; more economical use of available qualified nurse instructors and lecturers required for student nurses in a given area; saving of classroom equipment; increased number of qualified nurses to meet the demands of a national crisis; more highly qualified instructors; wider clinical nursing experience for the student; improved standards of the participating hospitals; keener student competition; an improved curriculum.

Further meetings are planned when the subject will be gone into in detail and it is to be hoped that we can proceed eventually with a plan for a Central School of Nursing.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Une Question

Chères Compagnes:

Décembre est le mois où l'on échange des lettres. Je ne veux pas laisser finir l'année sans vous écrire un mot. Je m'adresse à toutes les infirmières — aux religieuses, directrices, institutrices, hospitalières, qui, chez nous, assument la responsabilité de la formation de l'infirmière; aux infirmières diplômées des hôpitaux qui contribuent elles aussi à la formation des élèves.

Je m'adresse aux infirmières du service privé dont les intérêts économiques sont instables et souvent menacés et aux infirmières hygiénistes dont j'admire tant le dévouement et le patriotisme. Je m'adresse à celles qui sont isolées comme à celles formant un groupe bien uni. Je m'adresse à toutes les infirmières, même à celles qui ne le sont qu'en herbe, aux élèves de nos hôpitaux.

L'Association des Infirmières du Canada publie un journal officiel intitulé *The Canadian Nurse*. Dans ce journal sont publiées les activités importantes des neuf associations provinciales; l'on y rapporte aussi des faits se passant dans d'autres pays, susceptibles d'intéresser les infirmières.

La valeur des renseignements donnés dans cette revue, la nécessité toujours de plus en plus grande de se tenir au courant des choses de notre profession ont déterminé nos représentantes à l'Association des Infirmières du Canada de demander au conseil de publier en français les notes du secrétariat et un article également dans notre langue. Le but de cette demande était de permettre aux infirmières de langue française de se renseigner sur la politique de l'Association des Infirmières du Canada et aussi sur celles des autres provinces. Pour atteindre ce but, depuis avril 1946, tous les mois, les notes du secrétariat ont été traduites et un article en français a paru.

La question des aides a été longuement étudiée; celle des conditions de travail dans les autres provinces du Canada et dans d'autres pays ont été rapportés dans les notes du secrétariat.

En quinze minutes de lecture, l'infirmière peut se rendre compte des études, à l'ordre du jour et des faits pouvant avoir des répercussions, non seulement sur la profession en général mais pouvant affecter sa manière de penser et de vivre.

Pour être renseignée, il faut nécessairement prendre connaissance des faits concernant l'objet de notre intérêt. Je me demande si les infirmières de langue française sont renseignées sur la profession d'infirmière au Canada. Par le nombre d'abonnées à la revue, soit 81, je serais tentée de répondre: "Non."

Notre profession, comme le monde actuel, est à un tournant. Il semble nécessaire, plus que jamais, que chacune d'entre nous soit renseignée et se fasse une opinion.

Chères compagnes, je viens vous demander si vous désirez la continuation de ces pages françaises. Sont-elles utiles à vos élèves lors de l'enseignement des problèmes et de la politique

951

DECEMBER, 1947

de la profession? Y trouvez-vous de la matière pour les conférences des hospitalières, pour les réunions des amicales, et pour les assemblées des infirmières de districts?

Dans la lecture, en particulier, de ces pages, infirmières du service privé, vous tenez-vous au courant des événements? A toutes, je demande une réponse, qu'elle soit affirmative et concrète, je la souhaite, mais quelle qu'elle soit, faites moi connaître votre opinion en toute sincérité.

Cette revue n'a pas la prétention d'être parfaite, ni de répondre à tous les besoins des infirmières, mais elle

répond à certains besoins et donne certains renseignements officiels qu'il est impossible de trouver ailleurs.

Nos pages françaises vont-elles mourir avec la vieille année ou renaître avec le nouvel an? Une vie de plus vous est confiée, qu'en ferez-vous?

Je termine cette longue lettre, chères compagnes, en vous offrant tous mes voeux de Joyeux Noël. Soyez heureuses . . . que l'année soit bonne pour chacune d'entre vous . . . et que le Bon Dieu vous donne le Paradis à la fin de vos jours.

Sincèrement vôtre,

SUZANNE GIROUX

Arthritis



Around the Council Table

Members and advisers of the interim committee of the Canadian Arthritis and Rheumatism Society, organized recently in Ottawa, get down to work. Left to right around the table are: Dr. H. A. Ansley, Ottawa, assistant director of health services, Department of National Health and Welfare; Dr. R. Dandurand, associate professor of medicine, University of Montreal; Dr. J. B. Collip, London, Ont., dean of medicine, University of Western Ontario, and director of medical research, National Research Council; Dr. G. D. W. Cameron, Ottawa, Deputy Minister of National Health; Dr. Wallace Graham, Toronto, Canadian Rheumatism Association; Hon. Paul Martin, Minister of National Health and Welfare; Sir Andrew Davidson, chief medical officer for Scotland; Dr. T. C. Routley, Toronto, general secretary, Canadian Medical Association; Dr. F. W. Jackson, Winnipeg, Deputy Minister of Health and Public Welfare for Manitoba; Miss Ethel M. Cryderman, Toronto, first vice-president, Canadian Nurses' Association; and J. S. L. Browne, faculty of medicine, McGill University, Montreal.

A few of the pertinent data regarding arthritis will indicate how important the work of this committee is. A booklet issued by the Greater Vancouver Health League indicates that for every case of tuberculosis there are ten of arthritis; one heart case to two of arthritis; one of diabetes to ten and one of cancer to seven of arthritis.

The average age of arthritis sufferers is forty-one years. The average age of those permanently crippled is fifty-five years.

Arthritis accounts for a greater number of days lost from work than any other chronic ailment except nervous and mental diseases.

Notes from National Office

No Racial Discrimination

IT HAS BEEN brought to the attention of the Canadian Nurses' Association, through the medium of the press, that the National Council of the Young Women's Christian Association conducted a survey among schools of nursing in Canada on the question of racial discrimination. The results of this survey have been published in various papers across Canada. It appears wise and timely that all nurses, as well as others, should know the policy of the Canadian Nurses' Association concerning racial discrimination, which is as follows:

The Canadian Nurses' Association in general meeting, June, 1944, again reaffirms its policy concerning racial discrimination by resolution:

WHEREAS, It has been brought to the attention of the Executive of the Canadian Nurses' Association that certain racial discriminations are practised in some Canadian schools of nursing, therefore be it

Resolved, That the Canadian Nurses' Association, at this 22nd biennial convention held in Winnipeg in 1944, reaffirm its policy to support the principle that there be no discrimination in the selection of students for enrolment into schools of nursing.

This resolution was unanimously adopted.

Obtaining Information

During the past few months, several questionnaires have been circulated to the schools of nursing in Canada for the purpose of securing explicit information. This information is being sought by the Department of National Health and Welfare which has requested data concerning the nursing personnel of Canada, with special emphasis on the maximum potentialities for training additional

student nurses. Facilities for training subsidiary workers are also being clarified.

Another questionnaire seeks to gain a true picture of the present shortages in general staff, head nurses, supervisors and instructors in our schools of nursing and other hospitals, including tuberculosis sanatoria and mental hospitals. Similar data are being secured for public health nursing services.

The third topic of interest is a study of the number of student nurses who withdraw from training and the reasons for these withdrawals. In order to facilitate reporting and to provide comparable data, the directors of the schools of nursing are being asked to record the information for future classification. Where withdrawal appears to be due to more than one reason, the *predominant* cause is to be recorded. The following list forms the basis of this problem in nursing research:

- 1. Failure in class work.
- 2. Failure in clinical practice.
- Failure to meet school's regulations and social standards.
 - 4. Immaturity
 - 5. Health.
- Personality and temperament unsuits able for nursing.
 - 7. Disappointment in nursing course.
 - 8. Dislike for nursing.
 - 9. Matrimony.
- 10. Personal reasons: Family complications, death in family, homesickness, pregnames, transcal reasons, decision to go to college
 - 11. Other reasons: Specify.

National League of Nursing Education

The 51st annual convention of this body was held in Scattle, Wash, Sep-

tember 8-11, 1947. Miss Evelyn Malory, Vancouver, second vice-president of the Canadian Nurses' Association, represented us on this occasion. Miss Mallory, in collaboration with Miss Alice L. Wright, executive secretary, R.N.A.B.C., has prepared a most interesting and stimulating report on the proceedings for presentation to the Executive Committee, C.N.A. Space precludes the possibility of printing this entire report but many of the highlights follow:

To be able to attend this meeting at which were present so many of the leaders in the field of nursing education in the United States and to hear them discuss their problems was a very stimulating experience and a most enjoyable one for me personally. I returned feeling that I had attended an institute planned to meet my own specific needs; that our thinking here in Canada is very similar to that of our neighbors; and that Canadian nurses owe much to the League. For years we have made extensive use of their studies and we shall no doubt continue to do so. We modify them to meet our own needs, but the basic ideas are often essentially theirs. I sometimes wonder if we might not make more effort for ourselves if we did not have that valuable source of help so close at hand. I came home firmly convinced that we in Canada have no counterpart to the National League of Nursing Education and that we need one badly.

A minimum amount of time on the total program was devoted to a consideration of routine reports. At the opening business session on Monday morning the reports of officers, committee chairmen, etc., were accepted as recorded in the printed booklet given to each nurse as she registered. This undoubtedly facilitated the submission of reports but did not encourage discussion or questioning. Though it was possible to obtain these reports by registering on Sunday, one felt that very few nurses had read them or were very familiar with their content.

Program: The total program was very aptly entitled "Nursing Education for Public Service." Topics were presented by means of panels, round tables, symposia, and by special speakers, all experienced in the various fields on which they spoke.

Public relations: In public relations Mr. Byron Christian pointed out that the field of public relations has just grown, that it developed first in business but has now spread to practically all other activities. He gave various interpretations of the meaning of "public relations" such as, it is the business of getting along with people. It is being good and getting credit for it! It is 90 per cent doing right and 10 per cent talking about it! It is a planned program of policies and conduct which will build public confidence and increase public understanding.

The aim should be to win friends (for the organization or the service) on a permanent basis. A planned program is essential but, in the planning, policies and conduct are of the utmost importance. What is needed is not propagandists but persons who will inform the public truthfully of what we have to offer.

Participants in the symposium that followed emphasized that public relations in the school of nursing is a two-way process, that is, we need better public relations to attract desirable applicants and it is within the power of the school of nursing to produce graduate nurses who will themselves sell the product to the public.

Student nurse recruitment: One speaker stated that today women have twenty thousand jobs to choose from and that nursing education is competing with many other fields for the upper 10 per cent of the group graduating from high school. Possibly nurses are over-emphasizing the special fields and planning for tomorrow, thereby neglecting the needs for general bedside care for those in hospital today. She advocated putting more emphasis on the service aspect of nursing because the ideal of service appeals to young girls. Another speaker advocated not charging tuition fees but paying allowances. The A.H.A. urges the elimination of all legal requirements in relation to age.

Nursing education and its relation to general education: Dr. Eldon Johnson, of the University of Oregon, stated that we must ask ourselves what is the proper relationship between a liberal and professional education; what factors are needed to strike a happy balance. He said we need more emphasis on social science, the humanities. We need education for life as well as education for livelihood.

Dean Margaret Tracy, of the University of California, said that our major concern is for better nursing education and our major problem is how to get it. She mentioned the tremendous range in the size of hospitals operating schools of nursing. Do we know what size of hospital will give the best pre-

paration? What size of student body will result in the best preparation and what size is most economical from the standpoint of nursing education? Miss Tracy put the question: How can research help us? She said, "Research is a high-hat word that scares people." It means going out and looking for change instead of waiting for change to come to us.

Dr. Esther Lucille Brown's "Progress Report on the Study of Schools of Nursing" was the highlight of the whole convention. Dr. Brown said that her observations thus far had led her to certain conclusions in relation to nursing: (1) Hospitals require terrifically large staffs. (2) As research continues the type of service required becomes increasingly complex in nature. She listed eleven implications for nursing and outlined new patterns of nursing education that must emerge therefrom. Some of her points were:

There is a noticeable trend for doctors to delegate more responsibility to nurses. Nurses carry the responsibility for the care of the acutely ill. Curative care is eating up funds and restricting the development of preventive programs. Nurses should not waste their energies in tasks that can be performed by attendants and practical nurses. In conclusion Dr. Brown felt that when one considers the activities and responsibilities of the professional nurse it is very evident that a high school education is not sufficient. She needs to have the ability to assume initial, continuing, and final responsibility. The nurse should have at least two years of broad cultural education beyond the level of high school, followed by a professional education. Who shall organize and direct nursing education? It seems obvious that the university or some other institution of higher learning should organize, direct, and control nursing education.

Practices in our schools of nursing: Miss Blanche Pfefferkorn provided some interesting information. In 1943, 81 per cent of the schools of nursing required 18 years or over as an admission age for students. In 1946, 55 per cent required 18 or over, 28 per cent 17 to 18, 17 per cent less than 17. In 1932, 78 per cent of the schools of nursing granted allowances; in 1946 only 14 per cent granted allowances.

Understanding of the curriculum: At this interesting round table the opening speaker stated that many of our difficulties in schools of nursing are due to a lack of understanding of the curriculum on the part of many who

contribute to the program of the school of nursing. She stated the following problems as examples:

- 1. The emphasis that head nurses and doctors place on service as opposed to education as evidenced by their opposition to the amount of time that the student "wastes" in the classroom and in classes held on the ward.
- Doctors who come late for their lectures. sometimes as much as half an hour late!
- Poor experience assignments to student nurses, assignments being based on service needs rather than on the learning needs of the student.
- 4. Requests from agencies providing affiliated programs that students come better prepared for this experience in order that they may more quickly fit into the service.
- 5. Students carrying too many non-nursing and non-learning activities.
- Inadequate facilities provided for teaching.
- 7. The criticism that nurses are being educated away from the bedside.

The following suggestions for improving the understanding of the curriculum and so improve the education of the student were made: The director of the school should have a democratic program. To establish good rapport requires careful planning for meetings. It is a good idea sometimes to have members of the board and/or the school of nursing committee attend faculty meetings, not specially selected meetings where everything goes well. It does no harm for members of the board to appreciate some of the difficulties. Select articles appearing in the professional journals and give them to members of the school of nursing committee to read, and follow this up with a discussion of the article. The personnel of the school of nursing committee should include leaders from the field of general education. Promote better understanding among the physicians by soliciting their participation in the teaching program; getting their participation on nursing committees; learning how to supply good and sufficient nursing service by effective utilization of auxiliary workers. The students themselves should have a careful orientation to the school and to each new operation of the program; participation on faculty committees in reference to the school; student and faculty student organizations.

Guidance program in the school of nursing. Miss Phoebe Gordon, of the University of Minnesota, stated that faculty interest and participation is very essential in a guidance program. A trained counsellor is not necessary but is desirable. Guidance is an important part of every teacher's responsibility.

Health statistics: The speaker who introduced this topic made the statement that the term "Vital Statistics" is obsolete, that "Health Statistics" is to be preferred. It was pointed out that the nurse must be able to see her work in relation to the community, that it is extremely difficult, if not impossible, to separate health from social statistics and that, therefore, it seems logical to incorporate into the basic curriculum a modification of the statistical course that is now included in most post-graduate public health nursing courses.

The need for adequate preparation of the faculty as a whole was emphasized since all members would have an opportunity to contribute in some way and at some time to this phase of the student program.

Advanced courses in special fields of nursing: Out of the panel discussion on this topic the following are some of the points which were made: Any nurse should have advanced experience and preparation in the field in which she proposes to teach or supervise. We have been imposing the principles of teaching and supervision on an inadequate basis. Our present aim should be to develop the opportunity for further preparation and advancement in qualification that does not mean further removal from the patient.

Notes du Secrétariat de l'A.I.C.

Politique de L'A.I.C. Concernant la Distinction de Race

Par la voix des journaux, l'attention de l'Association des Infirmières du Canada a été attirée sur une enquête menée par le conseil national du "Young Women's Christian Association" à savoir: "Si, dans les écoles d'infirmières, l'on faisait une distinction entre les races." Le résultat de cette enquête fut publié dans plusieurs journaux du Canada. Il semble sage et nécessaire de faire connaître à toutes les infirmières, de même qu'au public, la politique de l'A.I.C. à ce sujet, qui est le suivante:

L'Association des Infirmières du Canada, lors de son assemblée générale en juin, 1944, a, une fois de plus, réaffirmé sa politique concernant la distinction de race par la résolution que voici:

Comme il a été porté à l'attention du conseil exécutif de l'A.I.C. que les distinctions de races étaient faites dans certaines écoles d'infirmières du Canada, il a donc été résolu que l'A.I.C., à son 22e congrès biennal tenu à Winnipeg en 1944, réaffirma sa politique supportant le principe qu'aucune distinction de race soit faite dans le choix des étudiantes désirant s'inscrire dans une école d'infirmières.

Cette résolution fut adoptée à l'unanimité.

RENSEIGNEMENTS REÇUS

Durant ces derniers mois, l'on a fait circuler plusieurs questionnaires dans les écoles d'infirmières du Canada dans le but d'obtenir des renseignements précis.

Ces renseignements étaient demandés par le Ministère National de la Santé et du Bien-Etre au sujet du personnel hospitalier au Canada sur le nombre maximum d'infirmières pouvant être formées dans nos écoles. La possibilité de former des aides est aussi étudiée.

Un autre questionnaire avait pour but d'obtenir un tableau réel de la pénurie d'infirmières en service général, hospitalières (head nurse), surveillantes et institutrices dans nos écoles d'infirmières et dans nos hôpitaux y compris les sanatoria et hôpitaux pour maladies mentales.

Le troisième questionnaire avait pour but d'étudier le nombre d'infirmières quittant nos écoles et la cause de ces départs. Comme d'autres rapports seront demandés plus tard et afin de pouvoir faire la comparaison entre eux, on a demandé aux directrices des écoles de continuer à noter ces renseignements.

Lorsque l'élève quitte l'école pour plusieurs raisons, la plus importante cause doit être notée.

Afin de faciliter l'étude de ce problème, les causes de départ énumérées ci-dessus sont à la base du problème étudié par les infirmières: (1) Ne réussit pas en classe. (2) Ne réussit pas dans son travail pratique. (3) Ne peut suivre le règlement, ni se tenir à la hauteur de l'école. (4) N'a pas la maturité voulue. (5) Mauvaise santé. (6) N'a ni

la personnalité, ni le tempérament convenant à une infirmière. (7) Déception concernant le cours d'infirmière. (8) Déteste le soin des malades. (9) Doit se marier. (10) Raisons personnelles: (a) difficultés familiales; (b) mortalité dans la famille; (c) ennuie; (d) grossesse; (e) embarras pécuniaires; (f) études supérieures.

Assemblée Annuelle de la "National League of Nursing Education"

La "National League of Nursing Education" a tenu sa 51e assemblée annuelle à Seattle, Wash., du 8 au 11 septembre 1947.

Mlle E. Mallory, de Vancouver, 2e viceprésidente de l'A.I.C., fut notre représentante. Mlle Mallory aidée de Mlle A. Wright, secrétaire de l'Association des Infirmières de la Colombie-Britannique, a préparé un intéressant et encourageant rapport sur ce congrès, qui sera présenté au conseil de l'A.I.C. Le manque d'espace ne nous permet pas de publier ce rapport en entier, mais voici quelques-uns des principaux faits:

Le fait d'assister à une assemblée où se trouvent réunis les maîtres de l'éducation en nursing aux Etats-Unis et de les entendre discuter de leurs problèmes fut pour moi une expérience très encourageante et très intéressante.

En revenant j'ai fait les réflexions sui-

Que j'avais assisté à des conférences préparées dans le but de répondre absolument à mes propres besoins; que notre façon de penser au Canada et aux Etats-Unis est souvent analogue; que les infirmières canadiennes ont de grandes dettes envers la National League; depuis des années nous nous sommes servies de leurs études et probablement que nous continuerons à le faire; ces études sont modifiées de façon à convenir à nos besoins, mais les idées, à la base, restent très souvent celles mêmes de la National League.

Je me demande parfois si nous ne pourrions pas, pour notre propre compte, faire un plus grand effort, si nous n'avions pas à la portée de la main, une source de renseignements de si grande valeur. Je reviens au pays, convaincue qu'au Canada, nous n'avons aucune organisation pouvant se comparer à la "National League of Nursing Education" et pourtant nous en avons grandement besoin.

Très peu de temps fut alloué à la lecture des rapports ordinaires. A la séance d'ouverture, le lundi matin, les rapports des officiers des convocatrices des comités, etc., furent acceptés tels que présentés dans le livret remis à chacune des infirmières inscrites. Ce procédé facilita l'adoption des rapports mais ne favorisa pas la discussion. Ces rapports ne pouvant être obtenus que le dimanche, lors de l'enregistrement, l'on peut penser que très peu étaient au courant du contenu.

Programme: Tout le programme était résumé sous ce titre général: La formation de l'infirmière en relation des besoins du public.

La matière fut présentée au moyen de discussion par groupe, conférences intimes, symposium, et par des conférenciers qui parlèrent de sujets qui leur étaient très familiers.

Relations extérieures: Les relations extérieures, qui se sont d'abord développées dans le monde des affaires, s'étendent maintenant pratiquement à toutes les autres activités, fit remarquer Monsieur B. Christian.

Le terme "relations extérieures" a bien des sens tel que: Bien s'entendre avec les gens; avoir de la valeur et de se faire apprécier en raison de cette valeur; mettre 90 pour cent de son application à faire un bon travail et 10 pour cent à en parler. C'est encore faire connaître un programme préparé, une politique et une conduite qui gagnera la confiance du public et augmentera sa compréhension. Le but doit être de se faire des amis (pour l'organisation ou pour la cause) permanents.

La préparation d'un programme est chose essentielle, mais la préparation de la politique qui déterminera la conduite à tenir est de la plus grande importance. Ce dont nous avons besoin, ce ne sont pas des propagandistes, mais des personnes susceptibles de renseigner sincèrement le public sur ce que nous avons à lui offrir.

Les participants insistèrent, lors du symposium qui suivit cet énoncé, sur les relations extérieures dans l'école d'infirmières que l'on peut comparer a un chemin double partant d'un point et y revenant, à savoir: L'école a besoin de meilleures relations extérieures pour recruter des candidates désirables et il est du pouvoir de l'école d'infirmières de produire des infirmières diplômées dont la réputation et la qualité feraient la vente. En d'autres termes, la valeur des diplômes fait la réputation de l'école.

Le restat ment de l'étre approbler. Un des conférenciers affirma qu'aujourd'hui une femme pouvait choisir entre 20,000 positions et que les écoles d'infirmières entrent en lutte avec bien d'autres professions pour leur recentement parmi les 10 pour cent des

élèves finissant leur école élémentaire supérieure.

Il se peut que les infirmières insistent trop sur la spécialisation et pensent plus à demain qu'à aujourd'hui et du fait négligent le besoin général des soins aux malades, besoin qui se fait sentir actuellement dans les hôpitaux.

Cette conférencière demanda que l'on insiste davantage sur l'idée de servir. Cet appel de "servir" sourit aux jeunes filles. Un autre conférencier recommanda de ne rien charger pour l'enseignement, mais au contraire de donner une rémunération. L'Association des Hôpitaux américains demanda d'éliminer toutes restrictions concernant l'âge.

L'éducation de l'infirmière en rapport à l'éducation générale: Le Dr E. Johnson, de l'Université d'Oregon, dit que nous devions nous demander quelles relations doivent exister entre l'éducation libérale (qui exige surtout l'intervention de l'intelligence) et l'éducation professionnelle (formation technique). Quels sont les facteurs nécessaires pour atteindre un juste milieu entre les deux? Les sciences sociales et les humanités devraient occuper beaucoup plus de place dans le cours de l'infirmière. Nous avons besoin d'être éduqué pour la vie et non seulement d'être éduqué pour gagner sa vie.

Mlle M. Tracy, doyen de l'Université de Californie, dit notre préoccupation la plus importante est de donner une meilleure formation à l'infirmière et notre plus grand problème est de trouver les moyens pour atteindre à ce but. Elle mentionne la grande différence existant entre le nombre de lits dans les hôpitaux ayant une école d'infirmières. Savons-nous lequel de ces hôpitaux peut donner la meilleure formation à l'infirmière?

Quel nombre d'étudiantes aurons-nous lorsque nous donnerons la meilleure préparation? Au point de vue de la formation de l'infirmière, est-il plus économique à un hôpital d'un certain nombre de lits plutôt qu'à un autre d'avoir une école?

Un travail de recherche pourrait peut-être nous aider, demanda Mlle Tracy. Le mot "recherche" est un grand mot qui effraie bien des gens. Ce mot veut dire sortir de son habitude pour faire des changements, au lieu d'attendre que les changements parviennent jusqu'à nous.

Le rapport du Dr E. Lucille Brown sur le travail accompli à date sur l'étude des écoles d'infirmières fut le clou du congrès.

Les observations du Dr Brown dans les

hôpitaux l'ont amenée à faire certaines conclusions tel que: (1) Les hôpitaux ont besoin d'un personnel terriblement nombreux. (2) Dans les hôpitaux, il se fait beaucoup de recherches (chez le malade), dépistage, recherche des causes de la maladie, analyses, rayon X, etc. (Pour les médecins) l'expérience de traitements, compilations de cas, etc.

Et ce travail devient de plus en plus complexe, il s'en suit que le médecin confie beaucoup de ses responsabilités à l'infirmière. L'infirmière assume la responsabilité des patients atteint de maladies aiguës. L'on dépense une fortune à la guérison des maladies et il s'en suit que l'on manque de fonds pour développer une médecine préventive. Les infirmières ne devraient pas gaspiller leur énergie à des devoirs qui pourraient tout aussi bien être remplie par des aides.

Le Dr Brown dit que si l'on considère le travail et la responsabilité de l'infirmière professionnelle, il est évident que l'instruction qu'elle reçoit dans un cours primaire supérieur n'est pas suffisante. Elle doit être capable d'assumer une responsabilité continuelle, souvent en prendre l'initiative et la continuer au besoin et savoir quand la terminer.

L'infirmière devrait avoir, en plus de son cours primaire supérieur, deux années de culture générale qui seraient suivies du cours professionnel.

Qui doit organiser et diriger l'éducation de l'infirmière? Il semble évident que les universités ou autres institutions d'éducation soient chargées de l'organisation, de la direction et du contrôle de l'instruction de l'infirmière.

Pratiques courantes dans nos écoles d'infirmières: Mlle Blanche Pfefferkorn nous donna des renseignements intéressants sur quelques pratiques courantes dans nos écoles. En 1943, dans 81 pour cent de nos écoles l'on exigeait que les candidates admises aux écoles soient âgées de 18 ans. En 1946, 55 pour cent de nos écoles exigent qu'elles soient âgées de 18 ans ou plus, 28 pour cent de 17 à 18 ans, et 17 pour cent moins de 17 ans. En 1932, 78 pour cent de nos écoles donnaient une rémunération aux élèves. En 1946, ce nombre est tombé à 14 pour cent.

La compréhension du programme d'étude: Bien des difficultés dans nos écoles d'infirmières résultent d'un manque de compréhension de la part de personnes prenant part à la réalisation du programme d'étude, par exemple:

1. Trop souvent les médecins et les hos-

pitalières parlent avec trop d'insistance du temps que les élèves perdent en classe et durant l'enseignement clinique au lieu d'être au service des malades.

- Les médecins qui arrivent en retard aux cours, des fois même jusqu'à une demiheure de retard.
- 3. L'expérience pratique des élèves est souvent négligée; les élèves sont souvent envoyées dans les services non pour ce qu'elles ont besoin d'apprendre mais pour répondre aux besoins de l'hôpital.
- 4. L'on apprécie par les possibilités d'affiliation avec d'autres institutions, ce qui permettrait aux élèves d'être mieux préparées une fois sortie de l'école.
- Les élèves font trop de choses non professionnelles et des choses qui ne leur apprennent rien.
- Les conditions ne sont pas favorables à l'enseignement.
- 7. Les critiques qui se font que la formation de l'infirmière se fait loin du lit du malade.

Voici quelques suggestions de nature à favoriser la compréhension du curriculum et ainsi améliorer l'enseignement chez les élèves. La directrice de l'école doit avoir un programme démocratique. Pour qu'il y ait entente entre les divers membres chargés de l'exécution du programme (théorie et pratique) des assemblées régulières doivent être préparées avec soin.

C'est une idée que d'admettre quelques fois des membres du bureau de direction et du comité des écoles à ces assemblées, non pas à des assemblées spécialement choisies où l'on sait que tout ira bien. Cà ne fait pas de tort que les directeurs se rendent compte de quelques-unes de nos difficultés.

Choisissez des articles paraissant dans les

revues professionnelles et donnez les à lire aux membres du comité de votre école, après ayez une discussion sur cet article. Parmi le personnel du comité des écoles, il doit y avoir un éducateur renommé.

Favorisez la bonne entente avec les médecins en leur demandant de participer à l'enseignement et ainsi les amener à faire partie du comité du nursing. Apprendre comment pouvoir donner suffisamment de soins aux malades en utilisant d'une façon adéquate les services des aides.

Les étudiantes mêmes devraient être mises au courant du travail qui se fait à l'école et de chaque nouvelle activité au programme.

Direction et orientation dans l'école d'infirmière: Mlle P. Gordon, de l'Université de Minnesota, dit que l'intérêt et la participation des membres de la faculté de l'école sont essentiels à l'exécution d'un programme d'orientation. Une personne spécialement préparée pour ce travail est conseillée mais n'est pas indispensable. La direction des élèves est une partie importante du travail de l'institutrice.

Cours supérieurs pour infirmières spécialisées: Ce sujet fut discuté par un groupe et voici quelques points discutés: Toute infirmière devant enseigner ou exercer une surveillance dans un des domaines du nursing devrait avoir une bonne expérience dans la matière et avoir reçu une préparation spéciale. Nous avons souvent demandé à des personnes d'appliquer les principes d'enseignement et de surveillance sans qu'elles aient la base nécessaire pour le faire. Actuellement notre but devrait être de favoriser la préparation et l'avancement de ces personnes tout en les gardant au chevet du malade.

Ice as a Local Anesthetic

For home use, or emergencies, or when the area is badly infected and an injection of novocaine is unwise, or where ethyl chloride causes too much pain because of its burning sensations, ice is the method of choice for anesthesia.

I have found ice to be useful in the following types of cases:

Infected toenails: Keep ice in sterile gauze to a previously sterilized skin for 20 minutes.

Carbuncle or boil: Ice works best in these cases; keep ice on area for 20 minutes.

Paronychia: Keep ice on for 10 minutes.

Dislocations of wrists, fingers, and elbow:
Keep ice on area with a little pressure, for

20 to 30 minutes.

Abscesses anywhere on or near the skin surface: Keep ice on area between 15 and 20 minutes.

Skin growths (nevi and the like): Keep ice on areas for 10 minutes and remove growth by knife or cautery.

in Medical Record, January, 1944

Nursing Profiles

Eugenie Margaret Stuart has joined the staff of the McGill School for Graduate Nurses in the capacity of assistant professor in school of nursing administration.

Miss Stuart has had a broad background of administrative experience and training as a preparation for her new work. Graduating from the Toronto General Hospital in 1925, she shortly became a head nurse in the surgical department there. In 1928 she enrolled in the certificate course in hospital administration and teaching at the University of Toronto School of Nursing. For the next five years she served as surgical supervisor and science instructor at T.G.H., joining the University of Toronto faculty as a clinical instructor in 1934.

The lure of distant fields called and in 1938 Miss Stuart joined the staff of Groote Schuur Hospital in Cape Town, South Africa, going to the General Hospital in Kimberley, S.A., the following year as sister tutor. She returned to Canada in 1940 to become superintendent of the Oshawa General Hospital. Last year, Miss Stuart further enriched her background when she obtained her B.S. degree in hospital administration at Northwestern University, Chicago, the first Canadian nurse to secure this standing. Her appointment to the McGill School strengthens the splendid opportunities available to nurses there.



Howard Smith, Chicago

EUGENIE STUART

The announcement was made recently of the appointment of Hazel Miller to the National Office staff of the Victorian Order of Nurses for Canada as travelling supervisor. After graduating from the Winnipeg General Hospital in 1934, Miss Miller engaged in private duty nursing and in addition had short periods of experience with the Winnipeg Branch of the Victorian Order of Nurses, the Metropolitan Life Insurance Company, and in the industrial field. In 1945, she attended Columbia University and obtained a B.S. degree in public health nursing, at which time she received valuable experience in supervision, followed by a period of staff duty with the Visiting Nurse Service of New York (formerly Henry St.).

Since obtaining her degree Miss Miller has been with the Winnipeg City Health Department, first as staff nurse then as tuberculosis consultant and more recently as district supervisor in the generalized public health nursing program. She has played an active part in professional affairs and was convener of the Public Health Section of the Manitoba Association of Registered Nurses, 1945-46.

Miss Miller is well qualified for her new responsibilities and the National Office staff look forward to their association with her.

Marjorie Gordon Russell, A.R.R.C., who was matron-in-chief of the nursing



HAZEL MILLER

service of the Royal Canadian Navy during World War II, retiring with the rank of commander, has assumed new duties as director of nursing at the Homoeopathic Hospital, Montreal. Born in Dhar, India, of Scottish and Welsh parentage, Miss Russell received her high school education in Northern Ireland. In 1923 she graduated from the Hospital for Sick Children, Toronto. She was in charge of the pediatric department at the Montreal General Hospital for three years, later returning to the Hospital for Sick Children where she was in charge of the Private Patients Department until her enlistment in 1941

· Marion E. (Paterson) Botsford is the new assistant registrar with the Registered Nurses' Association of B.C. Born and educated in Manitoba, Mrs. Botsford graduated as a Bachelor of Arts from the University of Manitoba in 1927. She enrolled in the school of nursing at the Royal Victoria Hospital, Montreal, completing her training in 1930. The following year she received her certificate in teaching and supervision at the McGill School for Graduate Nurses. Public health nursing, private duty, and general staff duty at Deer Lodge Hospital, Winnipeg, preceded her marriage in 1937. In 1941, Mrs. Botsford returned to nursing as assistant executive secretary and later acting registrar of the Manitoba Association of Registered Nurses. Friends, golf, and books mean much to the new assistant registrar.

Bernice Charlotte Underhill has been appointed matron of the King Edward VII Memorial Hospital, Bermuda. A native of New Brunswick, Miss Underhill had three years of public school teaching experience before she entered the school of nursing of the Montreal General Hospital. She remained there in various positions after graduating in 1932. Receiving a scholarship from M.G.H. in 1934, she enrolled for the certificate course in teaching and supervision at the McGill School for Graduate Nurses, then joined the school of nursing office staff of the Vancouver General Hospital. A year later she returned to M.G.H. going to Bermuda in the autumn of 1937. She joined the staff of King Edward VII Memorial Hospital in 1938 as instructor, becoming assistant matron in 1942. In March of this year, Miss Underhill completed a course in clinical teaching at Vanderbilt University, Nashville, Tenn., on a scholarship received from Lady Hall of Bermuda. Miss Underhill



MARJORIE RUSSELL

is fond of reading and music, is interested in travel and languages, and loves her game of golf.

Katherine Barr is assistant director, responsible for the educational program, with the Nursing Division of the City of Winnipeg Health Department. Miss Barr was born and educated in Winnipeg. She holds the



.

BERNICE UNDERHILL



ELLEN WICKLUND

degree of Bachelor of Arts conferred by the University of Manitoba and also the collegiate teaching certificate granted by the Provincial Normal School. Prior to entering the school of nursing of the Winnipeg General Hospital in 1939, she was engaged for seven years as teacher in the public schools of Manitoba. Upon graduation, she entered the public health field, devoting the greater part of her time and effort to the child guidance and mental hygiene programs. The recipient of a generous scholarship from The Commonwealth Fund, Miss Barr spent a year at Columbia University, New York, where she received her Master's Degree in nursing education.

An honor, unique in nursing annals, was conferred upon Ellen G. Wicklund when she was named "Good Citizen" for Maple Ridge, B.C., by unanimous choice. A nurse for thirty years, Miss Wicklund started her career of service when she entered St. Barnabas Hospital, Minneapolis, in 1915. Many of her active years were spent in Saskatchewan. She settled in Maple Ridge fifteen years ago, answering the calls of illness in the homes throughout her community, the nearest hospital being many miles distant. Miss Wicklund is a keen gardener and lover of flowers, and spends as much time as possible between calls at this work she loves.

A very interesting experience is in store for Beulah Evelyn Holt and Gwyneth Goldsmith Jones. They have exchanged their positions for this year, Miss Holt going to the Vancouver Metropolitan Health Service and Miss Jones to the Elgin-St. Thomas Health Unit in Ontario. Miss Holt graduated from Victoria Hospital, London, Ont., in 1943, receiving her certificate in public health nursing from the University of Western Ontario, London, the following year. Miss Jones is a graduate from St. Paul's Hospital, Vancouver, with the class of 1938. She took a post-graduate clinical course at the Hospital for Sick Children, London, Eng., and in 1943 obtained her certificate in public health nursing at the University of British Columbia. Miss Holt enjoys music, poetry, and tinting photographs as her leisure-time activities while Miss Jones specializes in sports including badminton, riding, hiking, and skiing.

Hilda Muir Stuart, who since 1931 has been principal of the school of nursing of Victoria Hospital, London, where she graduated in 1913, has retired. During World War I, Miss Stuart served with the British Red Cross in Cairo, later joining the Q.A.I. M.N.S. for service in France then returning to Canada with the C.A.M.C. She is the proud possessor of the Mons Medal, the General Service Medal, the Victory Medal, and King George V Silver Jubilee Medal.

Miss Stuart has served as secretary-treasurer and chairman of District 1, R.N.A.O. She held membership in the Isabel Hampton Chapter of the I.O.D.E., all the members of which were graduate nurses. Miss Stuart's sphere of usefulness now includes the tasks of liaison officer between the hospital and its graduates. This is a recognition of her long record of faithful service and enables the Victoria Hospital to continue to make use of her unparalleled knowledge of the graduates.

Agnes Young Sutherland, who graduated from Royal Victoria Hospital, Montreal, in 1916 and who has been night superintendent there for more than two decades, has retired. Years ago, Miss Sutherland's initials were paraphrased in the school year book as "At your Service." Her unfailing interest in the welfare of the patients and her friendly guidance of the students under her direction have proven the validity of this phrase. She has decided to live in Brandon where she can have a garden and indulge her heart's desire to keep house and bake goodies. Miss Sutherland was presented, among other gifts, with a record-player on which she can satisfy her love for good music.

Ideals are like stars — we never reach them, but like the mariner on the sea, we chart our course by them.

—CARL SCHURZ

Dos and Don'ts in Nutrition

Dr. I. Rabinovitch, noted biochemist, who is director of the Institute for Special Research and Cell Metabolism in the Montreal General Hospital, and associate professor of medicine, McGill University, would like to see certain rules in cook books, and outlined the following "Dos and Don'ts" for housewives:

When buying apples, get small ones; the vitamins are concentrated just below the skin, and one pound of small apples contains more of the vitamins than a pound of large apples.

When purchasing leafy vegetables, select the thin leaf—pound for pound it contains more vitamins than the thick leaf.

Whenever possible buy only the day's needs—between gathering and serving, fresh vegetables lose as much as 50 per cent of their vitamin value.

Handle leafy vegetables carefully, because bruising of the leaves causes loss in vitamin value.

Dried green peas increase in vitamin value with the length of time they are soaked. If soaked for three or four days they have a higher vitamin content than even grapefruit.

Do not use baking soda to preserve the fresh green color of vegetables. The nutritional value is not in the color, and the ordinary heating with baking soda destroys vitamin C completely.

Potatoes boiled in their jackets are more nutritious than the peeled variety. Scraping potatoes wastes 5 per cent, peeling them wastes 20 per cent of the vitamin values.

Do not put vegetables in boiling water all at once. Shred them and put into the water a little at a time, without letting the water go off the boil.

Olive oil differs from vegetable oils from other sources in flavor only. It is in no way superior from a nutritional point of view.

Think in terms of the satisfying value of foods. Hunger may at times merely be due to an empty stomach and not to insufficient calories. Foods that remain longest in the stomach have the most satisfying value—bread and butter, bread and gravy, or hard-boiled eggs.

- Health News

In Memoriam

Carrie E. (Coleman) Bath, who was director of nurses for many years at St. Luke's Hospital, New York, died on September 13, 1947, in Paris, Ont., where she had resided since her retirement from nursing twenty-five years ago. Born in Grafton, N.S., Mrs. Bath trained at St. Luke's Hospital. Last year a scholarship named in her honor, "The Carrie E. Bath Scholarship," was awarded at St. Luke's for the first time.

Jessie Bell, who graduated in 1919 from the Galt (Ont.) General Hospital, died recently. Until a few weeks prior to her death, Miss Bell had served as a very active and faithful private duty nurse.

Alverna Debonardi, aged twenty-seven, a graduate of St. Joseph's Hospital, Chatham, Ont., died on September 30, 1947, from injuries received in an automobile accident. Miss Debonardi had worked at St. Joseph's Hospital following graduation.

Mrs. A.W. (Hunter) Eltherington, who

graduated in nursing in Regina in 1917, died at her home in Preston, Ont., on October 5, 1947.

Hannah J. (Cody) Grant, who was a member of the second graduating class of the Toronto General Hospital in 1884, died at her home in Toronto on September 27, 1947, at the advanced age of ninety-two years Mrs. Grant was the first superintendent and director of nursing of the Hospital for Sick Children, Toronto, serving from 1886 to 1891. In 1893, she married the late Rev. Dr. James Grant, a Baptist minister, who died in 1914.

Yvette Laporte, aged thirty, who graduated from Hotel-Dieu, Montreal, in 1943, died on September 19, 1947, from leukemia. Miss Laporte had refused to stop work despite her illness, winning for herself unstinting tribute.

Mrs. Hugh (Bell) Parks, a graduate in 1919 of Victoria Hospital, Prince Albert, Sask., died recently.

DECEMBER, 1947 963

STUDENT NURSES PAGE

Frost-Bite

Lois Riddell

Student Nurse, St. Elizabeth's School of Nursing, Sudbury, Ont.

Cause: "The temperature in downtown Sudbury is 20° below zero;" coolly says the voice of your favorite radio announcer. You adjust your scarf, pull up your collar, tighten your ear-muffs, and sally forth, undaunted by King Winter's attempt to bend you to his will. But you have not gone far when you wish that you were sunning yourself on Florida's sands, or skimming through space in a sleek airliner to some obscure tropical isle.

Even in the air Jack Frost may besiege you. During the last war, it was found that impatient air gunners, removing their gloves to "strip a gun" more conveniently, found to their surprise their fingers waxy white and solid as a rock. The damp wet fog of London is also an ally of King Winter. In the air-raid shelters, numerous cases of frost-bitten feet were reported at normal temperatures from 50° to 70°F. This demonstrated that winter robs body tissue of precious heat quickly.

Wind also plays havoc with tissue heat, and frost-bite occurs more easily when there is a wind present. The three causes of frost-bite then are:

cold air, water, wind.

Physiology: The physiology of Jack
Frost's disabling attacks on tissue is
that there is a slow lessening of the
flow of blood to the affected area because constriction of the tiny blood
vessels occurs, until circulation ceases
altogether. When the victim returns
to a warm place, the circulation re-

mains blocked for an hour or more, then it returns in a veritable flood. This congestion lasts from 16 to 18 hours. If the circulation ceases once again, necrosis sets in. During the stage of inflammation, tissue damage occurs. The small blood capillaries, damaged by the cold, break under the increased pressure of blood, and plasma leaks out, causing blockage of circulation, and tissue necrosis develops from lack of oxygen. Interesting discoveries leading to the explosion of ideas regarding treatment have been developed recently:

1. The age-old method of friction with snow was one of the first to be vetoed. Remember when grandma engulfed you in blankets, seated you near the stove, and brisky rubbed your frost-bitten ear or nose or toes with snow? Medical practitioners today frown upon this, on the theories that (a) the proximity of the stove and the friction of the snow cause heat. Heat brings a rush of blood to the constricted blood vessels, causing tissue damage; (b) water causes more tissue damage; (c) cold (snow) causes more tissue injury.

2. In a series of experiments with frogs, it was shown that frozen tissues are not brittle, and will not break off like an icicle.

3. It is the thawing out, not the solidification of tissues, that causes harm.

Treatment: The first step in treatment, of course, is prevention. This includes warmer clothing; precaution

against wet clothing; intensive teaching of the dangers of cold wind; cupping a gloved hand over a nipped ear

to keep in body heat.

The treatment when frost-bite is resolved has taken a definite change. As soon as the patient is brought indoors, the limb is elevated to lessen circulation to the restricted areas. An electric fan is the ideal method of keeping the limb cool and slow thawing is the essential method of treatment. If the fan is unavailable, ice bags may be used. Rolls of cellucotton may be placed around them to act as a thermos. This treatment lasts from six to seven days. On no account should moist dressings be placed on the limb, as this only furthers tissue damage.

If the hands or feet are frozen, pledgets of absorbent cotton or gauze should be placed between the fingers and toes to prevent the skin from sticking. The frozen parts should be gently supported with "doughnut" pillows and absorbent, so that the injured limb is spared as much pres-

sure as possible.

The serum in the blood being forced into the tissues promotes clumping

of the red cells, which may result in gangrene. To offset this, the use of a new anti-coagulant has been found beneficial. Heparin and Dicumarol have been found remarkably successful in this instance.

The patient may also suffer from upper respiratory infections which are treated by penicillin and the

sulpha compounds.

Fluids are given freely, and a sedative anti-spasmatic is usually ordered for the pain. These measures offset shock that may develop and help to combat spasm of the affected blood vessels.

In cases of frost-bite with tissue necrosis, amputation is inevitable. The space left may be repaired by skin grafts, or application of red blood cells may promote healing without grafts. Thermolite treatment usually follows both methods. Vitamin C is given also to promote tissue growth.

Modern science has caught Jack Frost napping, and found out his secrets at last. Don't let Jack Frost catch you napping! Dress warmly—wear your rubbers when it's raining. Whatever you do, don't stand still too long in below-zero weather.

Book Reviews

The Infant and Child in Health and Dis-

ease, with Special Reterence to Nursing Care, by John Zahorsky, M.D. and Elizatorth Noves, R.N. 496 pages. Published by The C. V. Mosby Co., St. Louis, Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1, 2nd Ltd. 1946. Illustrated. Price \$3.50.

Reviewed by Mrs. Edgeworth Burry, formerly Nurse in Casego, Children. Department, Royal Alexandra Hospital, Edmonton.

This tremendous subject has been covered in this, the second edition, by excellent judgment in the form of its presentation and omissions. Experience, commonsense, and simplicity are found in all the chapters.

The short paragraph on Discipline is food for thought as well as an appetizer. Nurses and parents need a great deal of help in this field. Chapter 2, Practical Hygiene, is very satisfying in the systematic handling of daily routine care of the infant. The mother's diet is discussed adequately and sensibly, as is the feeding of the infant and child which is of paramount importance for the well-being of both.

The interpretation of infants' stools is usually a stumbling-block for all but those with considerable experience. There are three excellent color plates on this subject.

The pediatric nurse requires knowledge of the common household poisons and hazards. In Part II, the treatment in emergencies of poisons and minor accidents has been included. This is frequently overlooked in pediatric textbooks, though it is very often encountered in hospital and home life.

This book is practical in the listing and

summing up of the diseases of infants and children with good illustrations and color plates. It is a very valuable book for all those who are seeking knowledge in the care of the well and the ill child. The authors have put countless hours of work and experience into a very presentable form.

Legal Aspects of Nursing, by Milton J. Lesnik and Bernice E. Anderson, R.N. 352 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. Price \$4.50.

Reviewed by James and Florence Wilson of Winnipeg, Man.

Most nurses, in common with other average non-lawyers, have only a very hazy notion of what the law and being a lawyer involves; to return the compliment, it may be said with confidence that very few lawyers have any idea at all of the daily routine of nursing, beyond the fact that it often involves changing dressings and preparing very neat but rather obscure charts. Nurses would recoil in horror from the suggestion that, even in thirty hours of study, the average lawyer could from a single volume obtain a clear insight into the duties and responsibilities of the professional nurse. Albeit, the authors of "Legal Aspects of Nursing" assume the ambitious task of providing for nurses a statement of the view taken by the law of almost every phase of their work.

On the whole, however, this onerous task is quite well done. "Legal Aspects of Nursing," written by a lawyer and a nurse, has been written "to state fundamentals of law which either explain the reasons underlying the manner in which activities of nursing or those closely identified with nursing are rendered or the consequences of failure to do so."

The first three chapters deal with the evolution of nursing and its legal control, the next three discuss the law of contracts, the seventh and eighth chapters are on the legal aspects of negligence and other torts, the ninth chapter deals briefly with crime, the tenth with wills, and the final chapter with formation of governments, courts, and legal procedure and trial.

We all know that the laws of one country are not the same as those of another and, therefore, in reviewing for Canadian nurses a book written by Americans, for American nurses, the prime factor one must consider is — Are the laws of the two countries similar enough to make "Legal Aspects of Nursing"

helpful to Canadian nurses? It will be obvious that the first chapters discussing registration of nurses and steps leading to it in the U.S.A., and the last chapter on formation of American governments and courts, although of interest to the Canadian nurse, depict the American scene only and, therefore, will not be particularly helpful to the Canadian nurse.

The remaining chapters, however, on contracts, negligence, assault and battery, slander and libel, crimes, and wills, which constitute the greater part of the book, should make interesting and worthwhile reading for the Canadian nurse, since there is enough parallel between the laws of the two countries on these topics. The discussion of contracts should be mentioned as being of particular value—what a contract is, who may make a contract, breach of contract, and so on — because nurses are continually entering into contracts.

Negligence is obviously of grave importance to all nurses and the authors caution: "The penalty for acting negligently may be greater than anticipated. The natural consequences which may flow from an initial act of negligence are limitless. Responsibility may ensue for all." This subject is treated in detail. Of particular note, on page 148 in a section entitled Nursing and Negligence (Malpractice), we find an extremely comprehensive definition of that difficult-to-define subject — nursing.

The book is liberally sprinkled with examples drawn from nursing situations, and although one occasionally feels that the examples are highly improbable—e.g., page 183 illustrating an assault — they do make the point more understandable.

On page ix of the preface the authors give it as their opinion that legal aspects of nursing should constitute a separate topic in the basic nursing course, and time-tables are provided to suggest how the contents of the book might be covered; in either thirty or fifteen hours. It is difficult to see quite how a school of nursing would have this much time available. There are other aspects of nursing whose teaching would easily claim priority over law as it concerns the nurse. In any event, whether the book is simply treated as required reading, or is used as the basic text for a separate course, the reference or the opening lecture should very clearly point the moral drawn in the first paragraph of this review. And it is humbly suggested that for a nurse to offer "valuable comfort and advice" to an accident victim on the probabilities of

his successfully sueing the other party (as the book says she may do on page 120) would be presumptuous.

However that may be, "Legal Aspects of Nursing" would certainly be beneficial reading for all Canadian nurses — perhaps a Canadian lawyer and a Canadian nurse will be inspired to produce a similar text.

The Practice of Mental Nursing, by May Houliston, R.G.N., R.M.N., R.F.N. 164 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Price \$1.75.

Reviewed by Barbara A. Beattie, Superintendent of Nurses, Provincial Mental Hospital, Ponoka, Alta.

This book is designed for the junior nurse to give guidance and understanding of the attitudes and techniques necessary for the care of the mentally ill. It also touches briefly on normal mental reactions of the individual and then proceeds to the abnormal behavior manifested in the disorders of the mind.

Miss Houliston stresses the qualities that must be developed in the successful psychiatric nurse stating that "there is no such thing as a born nurse" but that nursing "is an art and a discipline" which like all worthwhile things is "only learned by devotion and hard work."

Ward routine in mental hospitals is explained and precautions enumerated. Treatments used are also mentioned briefly, especially occupational therapy, recreational therapy, and psychotherapy. It also outlines the functions of a social worker in a mental hospital. The chapter on the history and development of mental hospitals is exceptionally well done.

While many of the terms vary somewhat from those used on this side of the Atlantic, taken as a whole it is a text that could be well recommended for elementary psychiatric nursing. Unfortunately, there are no illustrations used in the book, the addition of which might have given more "readerappeal." The summary with which each chapter is ended is useful in the preparation of teaching material.

Le Soin des Malades, Principes et Techniques. Rédigé en collaboration par les Soeurs de la Charité (Soeurs grises) de Montréal. 814 pages. Distribué à l'Institut Marguerite d'Youville, Ecole supérieure d'infirmières (affiliée à l'Université de Montréal), 1185 rue St-Mathieu, Montréal 25. Illustré. Prix \$6.50.

Revu par Soeur Jeanne Forest, directeur d'éducation, l'Hôpital Holy Cross, Calgary, Alta.

C'est avec beaucoup d'intérêt que j'ai étudié ce livre rédigé en collaboration par les Soeurs Grises de l'Hôpital Général de Montréal. Il sera certes bienvenu des étudiantes aussi bien que du personnel enseignant de nos écoles d'infirmières, les hospitalières qui exercent la surveillance dans les services, et toutes les infirmières diplômées, quel que soit d'ailleurs le champ de leur activité.

Le nursing, selon sa conception le plus moderne, y est considéré aussi bien comme prévention de la maladie par l'enseignement constant de l'hygiène que comme soin total du malade, soit à l'hôpital, soit à domicile, soit de jour ou de nuit. Le point de vue mental et religieux dirige tout le livre et celles qui le liront attentivement seront convaincues que pour bien remplir son rôle l'infirmière doit soigner "tout son malade."

Conformément au titre du livre, les principes servant de base à toute technique accompagnent chaque description et l'étudiante y trouve aussi les raisons, le pourquoi scientifique de chaque détail du traitement dans le but d'assurer le meilleur soin du malade. De nombreuses photographies, significatives et bien choisies, illustrent les différentes méthodes de traitement. Les techniques telles que décrites au cours du livre représentent les plus récentes améliorations dans le soin du malade et couvrent les nouveaux traitements et appareils aussi bien que les anciens. Les problèmes qui suivent chaque chapitre stimulent l'application pratique des théories énoncées et la liste des ouvrages à consulter est une auxiliaire bien précieuse pour quiconque veut élaborer le sujet étudié.

Ce livre est une mine de renseignements. Les auteurs méritent des félicitations et ont droit à la reconnaissance des infirmières canadiennes-françaises pour la composition de ce volume, fruit de nombreuses recherches, et le premier du genre publié dans leur langue.

Nurse-patient Relationships in Psychiatry, by Helena Wills Render, R.N. 346 pages. Published by McGraw-Hill Book Co. Inc., 330 West 42nd St., New York City 18, 1947. Price (in U.S.A.) \$3.00.

Reviewed by Elva Cranna, Superintendent of Nurses, Brandon Mental Hospital, Man.

This is a book for nurses which, in the author's own words, "helps you realize your proper function in the field of psychiatry and to show inter-relationship with general nursing."

Nurse-patient relationships are clearly presented. In teaching student nurses the basic principles of nursing care, these relationships are fully as important as clinical skills. This book deals primarily with nursing care from the viewpoint of behavior and emphasizes the patient as a person. The meaning of behavior and the nurses' responsibility in observing, recording, understanding, and modifying is well presented. Useful lists of words describing general appearance and behavior are included. A discussion of the close relationship of emotional and physical health shows the importance of nursing the patient as a whole.

The objectives of psychiatric nursing are clearly defined and well illustrated. The principal objective is to modify moods and change attitudes and the achievement of this depends on the management of interpersonal relationships. A comparison of psychiatric and general nursing care brings out the similarity and

shows that the only difference is in the shift in emphasis. The combination of their dominant aspects makes for perfection and completeness in each field.

, Nursing care is discussed under the headings: Remedial Approach, Primary Personality Disorders, Special Problems, Rehabilitation and Secondary Personality Changes. A bibliography at the end of each chapter is especially helpful to the teacher. The chapter on rehabilitation outlines the group of workers involved and the specific way in which each group contributes to the rehabilitation program of the patient. The nurses' responsibilities, as related to each group, are clearly stated. Special points of the nursing care are discussed with emphasis according to treatment units.

The final chapter describes the use of art, literature, and music in the understanding of the patient's emotional states.

This book deals with the reality and philosophy of nursing rather than with techniques and routines. Because of this it is of great value to both the teacher and the student in fostering the right "attitudes and understandings" of psychiatric nursing. It should find a place as a text or reference in psychiatric nursing in every school of nursing.

The Story of Menstruation

Over a period of the last two years, Walt Disney Productions in Hollywood have prepared a new educational movie for teen-age girls entitled "The Story of Menstruation." This sound film, using the medium of beautifully colored animation, accomplishes the extraordinary feat of teaching something essentially serious while preserving an air of good cheer by relieving the tension with unexpected humor.

This film has been built around the reasoning that substituting accurate knowledge for fear and mystery will help to create a healthy attitude towards menstruation. It is expected to banish girl-to-girl superstitions and misconceptions, and should serve to minimize the mental handicap which hampers many girls during this period. The idea of a natural and normal cycle of life is constantly stressed in the film.

Great care was taken with the choice of a narrator for "The Story of Menstruation" and a woman was finally decided upon. The reason for this choice lies in the fact that the voice, of necessity, should not call attention to itself by being too good or too bad; too glib or too amateurish. It had to take the part of a "big-sister."

The making of this film posed many difficult problems. Animation was, of course, a happy solution to most of these. A half-real and half-diagramatic rendering of the "glass-figure" technique was employed to show the internal organs. Medical language was simplified and unnecessary terms eliminated without a loss of essential accuracy. A gynecologist of the highest reputation checked the story in detail at every stage of its development; words, pictorial representation, animation and implications.

16 mm., 10 minutes long, in sound and in color, this film is available to educational institutions. Bookings for "The Story of Menstruation" will be handled by The Canadian Cellucotton Products Company, Limited, 330 University Avenue, Toronto 1, Ontario.

Nearly Halfway Therel

Slowly, the total of the War Memorial Trust Fund is rising. The necessity of getting copy to the printer early means that the most recent figures were assembled the end of October. They indicate some successes. Manitoba has passed its quota. Five other provinces show gains. In the remaining three, there has been no change since the last report. What new efforts have been made to reach the original objective? Will it be necessary to extend the closing date beyond this year?

The question has been asked: Why was such a large sum set as the objective? In arriving at the provincial quotas, the War Memorial Committee based the amounts on a donation of one dollar from each graduate nurse who was a paid-up member of her provincial association. The assigned quotas did not take into account the thousands of student nurses. Their solicitude for their fellow students has shown itself in contributions of food and clothing. They know how impossible it would be for them to study themselves had they no textbooks, no models, no visual aids. Have they been asked to help here?

The quotas did not provide for the thou-

sands of married or retired nurses who no longer have active membership. Many of them have given most generously of their time and effort to meet staffing needs in our hospitals and public health organizations. They are ready and willing to assist with other worthwhile projects, such as this Memorial Book Fund, when they are informed about them.

The last figures show that we have reached 44 per cent of the quota. Here is the present standing, those showing an increase being starred:

	.1 me	ount	Perce	nt of
Province	Coll	ected	Obje	clive
Manitoba	. \$2,	,161	108.	0*
Alberta	. 1,	798	89.	9*
New Brunswick		679	75.	5
Ontario	. 5,	,326	53.	3*
Saskatchewan		744	46.	5
Nova Scotia		661	41.	3*
Prince Edward Island		80	40.	0
British Columbia	. 1,	307	35.	3*
Quebec	1.	313	13.	1 *
Other gifts		16	-	-
	\$14.	085	44	1

University Training

Most recent figures show that a total of 50,600 veterans have received assistance in their university courses by way of payment of fees and living allowance. The record of these young veterans has been outstanding.

The percentage of failure has been small and reports from the universities across Canada show that a very large proportion of scholarships and prizes have been won by ex-service men and women.

Nursing Sisters' Association

The Calgary Unit is again able to report an active and successful year during 1947 with Mrs. S. S. Nelson as president. There is a membership of 65 with meetings held once a month that have been very well attended.

A quilt and parcels have been sent to an ex-nurse of St. Thomas's Hospital, London, Eng., as well as food parcels being forwarded to this hospital for distribution by the matron.

Food and clothing have been received by a Dutch nurse. Subscriptions for the Geographical Journal were sent to the DVA. Hospital and to the Veteran Convalescent Home. Red Cross war service pins were presented to a number of nursing sisters by Mrs. H. C. Ironside. A contribution was made by the association and individual members to the C.N.A. War Memorial Fund.

DECT MBER, 1947



THE IMPATIENT PATIENT

"Darn right I'm burned up. Wish somebody would tell my nurse about Blachford Shoes and then maybe she wouldn't snap my head off all the time." Yes, the patient has the right prescription. Blachford Shoes are built on scientific lasts, distinctively styled and designed for foot comfort that makes walking a pleasure. So don't let uncomfortable shoes get you down . . . try Blachfords, sold at better stores from coast to coast. Blachford Shoe Mfg. Co. Ltd., 3543 Danforth Ave., Toronto 13.

Memorial Vesper Services were held during May and a rummage sale in April netted \$90. One held in October was in aid of the Parcels Fund. Five hundred dollars is maintained as an Emergency Fund.

The June meeting was in the form of a garden party at the home of Mrs. J. T. Gray. The members assisted with floral arrangements for the Remembrance Day celebrations and the Armistice Day tea was held at the Palliser Hotel. Members also assisted with the sale of poppies. A pre-Christmas meeting will be held at the Col. Belcher Hospital with Miss L. Pearson, an exchange teacher, as guest speaker.

Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

British Columbia: APPOINTMENTS—Isobel Whitaker (Kitchener-Waterloo Hospital) as matron and Katherine McKim, from the R.C.A.M.C., to McBride outpost hospital; Janet M. Card (Clifton Springs, New York), matron, Kyuquot outpost; Doris T. Mc-Pherson (Toronto Western Hospital), matron, Eleanor M. Coulter (Toronto Western Hospital), Luella C. Brooks (Prince Rupert General Hospital), and Marjorie C. Doll (St. Joseph's Hospital) to newly-opened 10-bed outpost hospital, Terrace, B.C. Resignations—Gladys Keilty, matron, McBride outpost hospital, to be married; Jennie Stremecki from McBride outpost.

New Brunswick: APPOINTMENTS — The Tobique Valley Hospital, Plaster Rock, was opened recently with the following staff: M. A. Cooney (St. Michael's Hospital) as superintendent, Mary Stymiest (Soldiers' Memorial Hospital), Ruby Glencross (Soldiers' Memorial Hospital), Alice Farquhar (Fisher Memorial Hospital). Florence Keswick relieved Harriet Hughes (Ottawa Civic Hospital) during a leave of absence and has now returned to Kingston Hall Community Hospital. Greta Rubins (Saint John General Hospital), Laura Tomilson (Montreal General Hospital), and Hazel Salmon (Montreal General Hospital) served as relief nurses during vacations. Christina Harvey (Chipman Memorial Hospital) is now with the Grand Manan outpost hospital.

Nova Scotia: APPOINTMENTS - M. Jean

LIPPINCOTT NURSING TEXTS



for the

WARD LIBRARY

The vital necessity of a good ward library is apparent to every teacher in every subject

RELIABLE EXACT-EFFICIENT ... necessary to integrate classroom teaching with clinical teaching on the ward. Good source books are stimulating ... inspirational ... real aids to achievement in learning.

MEDICAL SERVICE

Emerson & Taylor

Essentials of Medicine

Kampmeier

Fundamentals of Psychiatry. New 4th Ed..... 4.50

Essentials of Dermatology.....

OBSTETRIC SERVICE

Zabriskie & Eastman

Nurses Handbook of Obstetrics

With entire management and nursing care of antepartum, parturition, postpartum and neonatal care. 7th Edition. \$4.00

Lull & Hingson
Control of Pain in Childbirth 9.00

Zabriskie
Mother and Baby Care in Pictures................... 2.75

SURGICAL SERVICE

Eliason, Ferguson, Farrand Surgical Nursing — 7th Ed.

Essentials of Proctology.....

5.00

3.00

Magnuson 7.00

PEDIATRIC SERVICE

Jeans, Rand, Blake
Essentials of Pediatrics

Emphasizes the precise nursing care related to specific disease conditions peculiar to childhood. 4th Edition.

isease conditions peculiar to childhood. 4th Edition. \$4.00 Hess & Lundeen

Newer Nutrition in Pediatric Practrice...... 12.50

Meek

Your Child's Development and Guidance Told in Pictures.

Prices of all books subject to change without notice.

6.00

J. B. LIPPINCOTT COMPANY

Medical Arts Building

Montreal 25, P.Q.

DECEMBER, 1947 971

1947 INDEX

SUBSCRIBERS WISHING TO RECEIVE COPIES OF THE 1947 Index

ARE REQUESTED TO COMPLETE THIS COUPON AND MAIL IT TO:

THE CANADIAN NURSE

Suite 522 — 1538 Sherbrooke St. W. MONTREAL 25 QUEBEC

Name (Please Print)	
Street Address		
City	Prov.	
Number of copies desired		

McInnis, assistant supervisor, Outpost Hospital Service, Nova Scotia Division; Shirley M. Beck, charge nurse, South Cumberland Memorial Hospital, Parrsboro.

Ontario: APPOINTMENTS-Juliette Fortin (McGill University public health course), field organizer, Department of Volunteer Nursing Services; Muriel Hay, B.Sc.N. (Victoria Hospital, London, and University of Western Ontario public health course) and Pauline McNee (Toronto General Hospital and University of Toronto public health course), field organizers, Junior Red Cross; Pearl A. Merriam (Victoria Hospital, London, and University of Western Ontario), in charge at Port Loring outpost hospital; Margaret Chattoe (Royal Victoria Hospital, Montreal, and University of Western Ontario), Wilberforce; Mary Cutler (St. Michael's Hospital, Toronto), Dryden; Bernadette McGarity (St. Michael's Hospital, Toronto), Rainy River; Mrs. Margaret Morrow (Victoria Hospital, Winnipeg), Red Lake; Kathleen Stanford (Kitchener-Waterloo Hospital), Hawk Junction; Dorothy Hall (Victoria Hospital, London), charge nurse, Hawk Junction; Dorothy Claridge, nursing assistant, Nakina; Lloydia Orr (Toronto Western Hospital) and Elsie Jenner (Chatham General Hospital), Beardmore; Vera Card, Apsley; Barbara Cox, Kakabeka Falls. E. Stronach, an English nurse, flew out from England to join the staff at Thessalon.

RESIGNATIONS: Grace McNaughton and B. Viney from Richard's Landing; Catherine Real from Hawk Junction, Margaret McNaughton from Espanola, and Vivian Goodreau from Hornepayne, all to be married; Irene Day from Atikokan.

TRANSFERS AND RELIEF: Betty Chinn (Royal Alexandra Hospital, Edmonton, and University of Alberta) returned to Queen's University to continue her medical course after relieving at Bancroft for the summer. E. Stephenson and Miss Rees, English nurses who came to Canada to take a year's course at the University of Toronto, relieved in outposts at Christmas time and, following the closing of the university year, worked their way to Vancouver. On their return they stopped off at Dryden and did floor duty there for three weeks before sailing for Eng-Mary Anderson (Torbay Hospital, Eng.) from Hawk Junction to Lion's Head. Mrs. Russell (Wright) Hawk did charge duty at Dryden during the summer. Mrs. Marjory (Foy) Beveridge returned to Thessalon for the summer. Temporary relief at Bracebridge was given by Dorothy Marshall and Olga-D'arbasie from Trinidad. Mrs. Jean (Mason) Shouldice and Mrs. Margaret Shouldice at Lion's Head. Mrs. Porter is now at Whitney. Marjory Rilett is taking the public health course at University of Toronto. Boskill, Port Loring, and Elsie Turner, Wilberforce, are taking the public health course at the University of Toronto on Red Cross scholarships. Betty McIntosh, Lion's Head, is also at the University of Toronto. Barbara Easton is at Nakina for two months. Mabel Easton has returned to New Liskeard after sick leave. Elaine Read, from Kakabeka Falls, is now public health nurse at Mindemoya following Mrs. Jean Noble.

Quebec: APPOINTMENTS — Catherine Keith, Barachois outpost, Gaspé; Mary M. LeBlanc, Douglastown outpost, Gaspé; Germaine Doiron, Grand Entrée outpost, Magdalen Islands. RESIGNATIONS—Mrs. Muriel Schonberg from Entry Island outpost, Magdalen Islands. Transfers—Elaine Corbett has resigned from Barachois outpost to become director, Home Nursing, Montreal Branch.

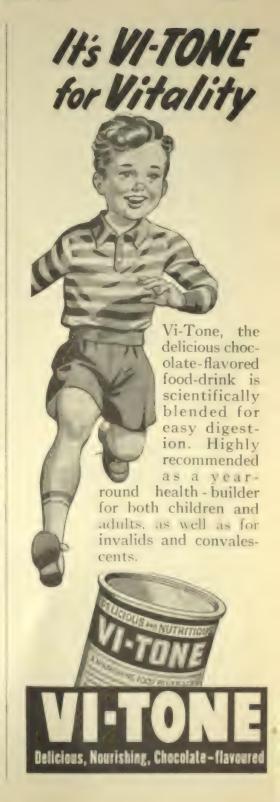
Saskatchewan: Appointments - Mary Donoghue, who has been with the Ontario Outpost Hospital Service, is now supervisor, Outpost Hospitals, replacing Jean Nichol. Frances Robertson and Marion Williamson (Victoria Hospital, Prince Albert), Hudson Bay; Patricia Cunning and Dilys Evans (Regina General Hospital), Loon Lake; Mary Lyons, on loan from Provincial Department of Public Health, charge nurse, Buffalo Narrows; Freda Kelm (St. Paul's Hospital, Saskatoon), supervisor, Regina Branch, Mothers' Milk Service Department. TRANS-FERS-Marion Roebuck, nurse-in-charge from Hudson Bay to Stony Rapids; L. Newell, nurse-in-charge from Leoville to Hudson Bay; E. Hockeley in charge at Leoville.

News Notes

BRITISH COLUMBIA

KAMLOOPS-OKANAGAN DISTRICT:

"Charting a Course in Nursing" was the subject on which Gertrude Hall spoke at a largely attended dinner meeting of the Kamloops-Okanagan District, R.N.A.B.C., held in Kamloops. Miss Hall, who is general secretary of the Camadam Nurses Amoriae



METROPOLITAN DEMONSTRATION SCHOOL OF NURSING

under the auspices of

THE CANADIAN NURSES'
ASSOCIATION

in association with

THE METROPOLITAN HOSPITAL WINDSOR, ONTARIO

Twenty-five month basic course in Nursing. Classes will enter in January 1948 and September 1948.

For further information write to:

The
Metropolitan School of Nursing
849 Kildare Road
Windsor, Ontario

McGRAW-HILL SERIES IN NURSING A Psychology of Growth by Bert I. Beverly, M.D., University of Illinois and Presbyterian Hospital, Chicago. \$2.75.

"Attempts to present the psychology of growth and development in a way which will help nurses to gain an insight into their own problems as well as those of their patients." J.A.M.A.

of their patients." J.A.M.A.

Careers for Nurses by Dorothy

Deming, R.N. \$3.85.

"A must for every nurse administrator or nurse educator, for every nursing library, and would be a well-chosen gift for any young nurse facing graduation." T.N. & H.R.

Solutions and Dosage by Sara Jamison, R.N. \$2.75.

"A clear-cut, direct, and logical approach to . . . the teaching of calculations of drugs and solutions." A.J.N.

tions of drugs and solutions." A.J.N.

A new catalogue of McGraw-Hill books of interest to Medical Personnel is now available. We shall be pleased to send copies upon request.

McGRAW-HILL COMPANY OF CANADA LTD. 12 Richmond St. E. Toronto 1, Can. tion, gave inspiration and guidance as she outlined projects and problems in nursing today.

At the business meeting it was stated that \$20 would be contributed towards the War Memorial Fund. Interesting reports and financial statements were given by the chapter delegates — Mrs. M. G. Rolph, Kelowna; Edna Williamson, Vernon; Mrs. E. Ransome, Kamloops; Norma Tucker, Princeton.

Returned to office were Mrs. M. Pigeau as president and Mrs. A. Mason, secretary-treasurer. Elected were: Public health section, F. Primeau; hospitals and schools of nursing, M. Humphreys; private duty and general nursing, Edna Williamson.

TRAIL:

At a meeting of Trail Chapter, R.N.A.B.C., it was revealed that a satisfactory sum was realized from the recent rummage sale. Donations were made to aid a nurse who is confined in the tuberculosis unit in Vancouver. After adjournment, the members listened to the broadcast by the local medical health officer, Dr. J. S. Daly, and his introduction of the public health nurses to the city of Trail and district. Three new members were welcomed to the chapter.

MANITOBA

BRANDON:

Marion Patterson, president of the Brandon Graduate Nurses' Association, was in the chair at a recent meeting. After a short business discussion the executive were hostesses at a friendly hour which was thoroughly enjoyed as graduates renewed old acquaintances and made welcome several new members.

NEW BRUNSWICK

SAINT JOHN:

At a recent well-attended meeting of Saint John Chapter, N.B.A.R.N., plans were made for a "Bring and Buy" sale, the object being to help bring the N.B. quota for the War Memorial Fund up to 100 per cent. A letter of appreciation for blankets and a quilt, given to the Rest-Breaks Home in England, was read. Dr. Earle Grant was the guest speaker and his talk on "Plastic Surgery" was very interesting and informative.

The General Nursing Section realized \$128 which was given to the local registry toward expenses.

Dorothy Fullerton was elected president of the Public Health Section at their recent annual meeting. Gertrude Burast and Constance Swinton, who are now on the V.O.N. staff, were welcomed as new members. Parcels for overseas are still being sent regularly.

General Hospital:

At a meeting of the Saint John General Hospital Alumnae Association Mrs. Handren and Hazel Tracey gave a report of the N.B. A.R.N. annual meeting. An interesting talk by Florence Lamb on her "Return Trip to Oslo" was also heard. A gift of ten dollars was given to St. Mary's Church toward the expense of its new chimes. Miss Tracey placed the wreath on the Cenotaph on Remembrance Dav.

An enjoyable event was the annual autumn dance given by the student body. Receiving the guesta were Miss Murdoch and Miss Peters. Norna Tedlie was the able convener, assisted by Misses Grass, Estey, Higgs, Allison, and

Sandford.

The junior nurses recently entertained the probationers when games were enjoyed and refreshments served. The committee of arrangements consisted of Dallas Robertson, Pauline Grass, Charleen Farmham, Norena Clarke, Barbara Baker, and Irene Powe. Misses Peters, Myers, Bell, and Hanscome represented the staff.

Ethel Reid is now on the teaching staff at Flushing Hospital, N.Y. Edyth Hunter, a Hartford Hospital (Conn.) graduate, has joined the surgery department. Kay Kincade, of Vancouver, is visiting Saint John for

the winter.

Lancaster Hospital:

The Lancaster Nurses' Association entertained at tea in honor of five members of the staff — two recent brides, two about to be married, and one who is leaving the staff to further her studies. The honor guests were Mmes D. Fitzpatrick and R. Martin, Misses Jean Guild and M. Parks, brides-elect, and Margaret McJunkin. Mrs. Fitzpatrick was the recipient of a wall mirror, Mrs. Martin a gift of linen, Miss Guild a lamp, Miss Parks a serving tray, and Miss McJunkin a compact. The tea table was presided over by the matron, Edna Dixon.

St. Joseph's Hospital:

Sr. M. Michael has gone to Prince Albert, Sask., to take charge of the orphanage. Sr. Theresa Carmel has returned to the staff after spending some time in western Canada. Sr. M. Joseph is supervisor, 2nd floor. Martina Carey is now on the staff. Elizabeth Wood resigned to be married. Frances Dionne has left the staff for Vancouver. Laura Harper is now at the Moncton Hospital.

NOVA SCOTIA

HALIFAX:

Children's Hospital:

Mrs. J. T. Luscombe and members of the committee of the Nurses' Official Directory recently entertained at a tea at the Sword and Anchor Inn in honor of Marjorie Jenkins, who resigned as superintendent of nurses.

Victoria General Hospital:

Mrs. J. T. Luscombe was in the chair at the first fall meeting of the alumnae association when 35 members attended. The association has been very active during the





LEEMING MILES CO. LTD., 504 St.Lawrence Blvd., Montreal 1, Canada

REGISTERED NURSES' ASSOC'N. OF BRITISH COLUMBIA Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director Placement Service 1001 Vancouver Block, Vancouver B.C.



Circulatory Regulator ond

Utero Ovarian Sedative

Particularly useful for Functional Dysmenorrhea. useful for

Excellent results have been obtained by commencing treatment a week or ten days preceding the expected period.

ROUGIER FRERES - MONTREAL

past months, food and clothing having been sent regularly to a needy English nurse. Mrs. H. S. T. Williams, treasurer, is the convener of this work.

A delightful tea was held in honor of the 1947 graduating class when the president, Mrs. Luscombe, and the vice-president, Dorothy Gill, received the 65 guests. Anna Brennan and Miriam Ripley presided at the tea table, assisted by several members.

ONTARIO

DISTRICT 1

LONDON:

The Community Nursing Registry recently sponsored a series of lectures when several interesting speakers were heard. Included on

the program were the following: Associate services: Mildred Walker, University of Western Ontario (Broad aspect of public health); Dorothy Mickleborough, National Office Supervisor, Victorian Order of Nurses; Florence Christie (Family service bureau). These lectures were given to acquaint the nurses with the various organizations available to their patients and how these organizations are involved when illness occurs. Legal Hazards in Nursing - Mr. A. B. Siskind, barrister. New Drugs — Dr. J. H. Geddes. After Care of Accident Cases — Dr. R. A. Johnston. Personality Studies in the Nursing Field — Dr. G. H. Stevenson. Physical Medicine and Rehabilitation - Dr. T. H. Coffey

Mildred Walker, faculty member, School of Nursing, University of Western Ontario, has returned from Teachers College, Columbia University, where she received her M.A. degree in personnel, administration and guid-

ance.

WINDSOR:

The Hotel Dieu Alumnae Association has made the following contributions: War Memorial Fund, \$50; Canadian National Institute for the Blind, \$100.

DISTRICTS 2 AND 3

ELORA:

St. John's Anglican Church, in which the innovation of a special service for nurses was instituted last year, welcomed approximately 250 nurses at a recent Sunday night service. As well as nurses from the immediate district, also in attendance were representatives from the hospitals of Fergus, Owen Sound, Guelph, Kitchener, Brantford, Stratford, Galt, and Woodstock.

In welcoming them the rector, Rev. C. J. Loat, explained the purpose of the service, which was to link this church, which treasured its association with Florence Nightingale, with the annual Sunday dedicated by the nurses in Canada for church service. With this in mind there had been worked into the new decoration of the church, the indistinct figure of a nurse, just over the niche in which the Nightingale Communion Service has been



HE is drawing a sample from a tank holding 24,000 quarts of chilled Carnation Evaporated Milk. And until that sample is laboratoryapproved for butterfat and total solids content. the milk is kept in "protective custody." Thus all Carnation Milk pauses on its way to the filling machines and sterilizers, to weld one more link in an unbroken chain of scientific controls . . . Carnation processing insures uniform composition and quality - a fact that goes far to explain the medical profession's high opinion of this acexpired brand

HOMOGENIZED-with buttertat minutely subdivided for easy assimilation.

FORTIFIED madiated to a Vitamin D potency of 400 Int unit-

STANDARDIZED for uniform ity in fit and total solids content

STERILIZED-after bermetic seal ing, insuring bacteria-tree safety and markedly diminished allergenic properties.



"From Contented Cows"

The Canadian Nurse

Authorized as second-class mail, Post Office Department, Ottawa.

**Editor and Business Manager:*

MARGARET E. KERR, M.A., R.N., Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

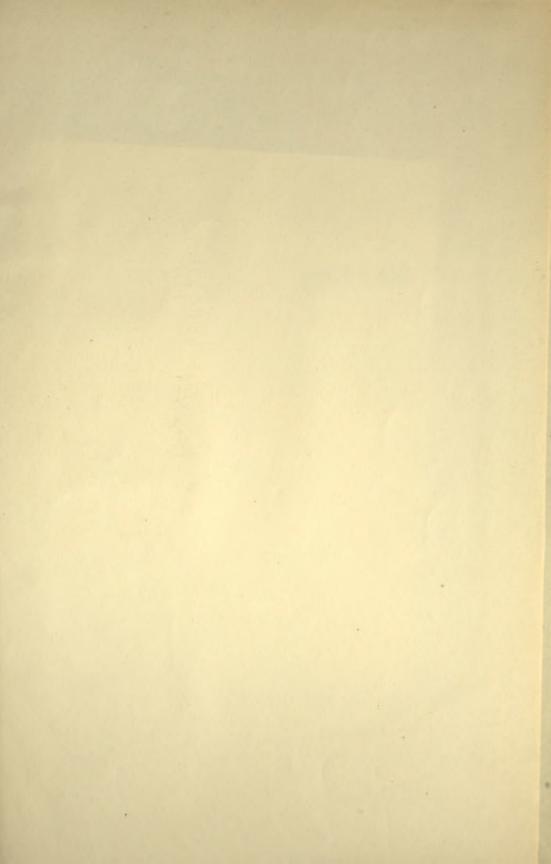
CONTENTS FOR DECEMBER, 1947

"Where We Gone"	919
CHRISTMAS DAY IN A JAP PRISON.	920
THE NURSE IN A CHANGING AGE	924
COMMUNICABLE DISEASE TECHNIQUES	929
RECREATION FOR STUDENT NURSES	933
Summary of the Working Party Report.	935
THE PRACTICAL SIDE OF EVALUATION	939
Enuresis	
A STUDY OF ISOLATION TECHNIQUE	946
Expansion of Clinical Facilities	
UNE QUESTION. S. Giroux	951
Notes from National Office.	953
Notes du Secrétariat de l'A.I.C.	956
Nursing Profiles	960
Frost-Bite	964
Book Reviews.	965
News Notes	973
Official Directory	983

The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse nor of the Canadian Nurses' Association.

Subscription Rates: \$3.00 per year — \$5.00 for 2 years: Foreign & U.S.A., \$3.50; Student Nurses, \$2.00 per year — \$5.00 for 3 years. Single Copies, 25 cents. All cheques, money orders and postal notes should be made payable to The Canadian Nurse. (When remitting by cheque, add 15 cents for exchange.) Change of Address. Four weeks advance notice, and the old address, as well as the new, are necessary for change of subscriber's address. Not responsible for Journals lost in the mails due to new address not being forwarded. PLEASE PRINT NAME AND ADDRESS. Editorial Content: News items must reach the Journal office before the 1st of mouth preceding publication. All published mss. destroyed after 3 months, unless asked for. Official Directory: Published complete in March, June, Sept. & Dec. issues.

Address all communications to Suite 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.



Réseau de bibliothèques Université d'Ottawa Échéance Library Network University of Ottawa Date Due

MAR 3 0 2001



